No. 19-30353

In the United States Court of Appeals for the Fifth Circuit

IN RE: REBEKAH GEE, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE LOUISIANA DEPARTMENT OF HEALTH; JAMES E. STEWART, SR., IN HIS OFFICIAL CAPACITY AS DISTRICT ATTORNEY FOR CADDO PARISH,
Petitioners,

JUNE MEDICAL SERVICES, L.L.C., ON BEHALF OF ITS PATIENTS, PHYSICIANS, AND STAFF, DOING BUSINESS AS HOPE MEDICAL GROUP FOR WOMEN; JOHN DOE 1, DOCTOR, ON BEHALF OF THEMSELVES AND THEIR PATIENTS; JOHN DOE 3, DOCTOR, ON BEHALF OF THEMSELVES AND THEIR PATIENTS,
Plaintiffs,

v.

REBEKAH GEE, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE LOUISIANA DEPARTMENT OF HEALTH; JAMES E. STEWART, SR., IN HIS OFFICIAL CAPACITY AS DISTRICT ATTORNEY FOR CADDO PARISH,
Defendants.

On Petition for Writ of Mandamus to the United States District Court
for the Middle District of Louisiana (Baton Rouge)
No. 3:17-cv-00404-BAJ-RLB

BRIEF FOR THE STATES OF TEXAS AND MISSISSIPPI AS AMICI CURIAE IN SUPPORT OF PETITION FOR WRIT OF MANDAMUS

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No. 19-30353

In re: Rebekah Gee, in her official capacity as Secretary of the Louisiana Department of Health; James E. Stewart, Sr., in his official capacity as District Attorney for Caddo Parish,
Petitioners,

June Medical Services, L.L.C., on behalf of its patients, physicians, and staff, doing business as Hope Medical Group for Women; John Doe 1, Doctor, on behalf of themselves and their patients; John Doe 3, Doctor, on behalf of themselves and their patients,
Plaintiffs,

v.

Rebekah Gee, in her official capacity as Secretary of the Louisiana Department of Health; James E. Stewart, Sr., in his official capacity as District Attorney for Caddo Parish,
Defendants.

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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STATEMENT OF INTEREST OF AMICI CURIAE

Amici are the States of Texas and Mississippi (the States).[1] The States have recently been sued by abortion providers pressing meritless theories similar to those advanced against Louisiana in this case. The States therefore urge the Court to hold that Louisiana is entitled to a writ of mandamus directing that plaintiffs' claims be dismissed.

Mississippi has been sued by plaintiffs represented by the same counsel in this case making similar claims with respect to Mississippi abortion laws and regulations. *See* filed Mar. 19, 2018). Plaintiffs have challenged Mississippi's entire regulatory scheme for licensing abortion clinics. Plaintiffs have also challenged the State's 24-hour waiting period law, informed consent law, restriction on non-physicians performing abortions, and the State's prohibition on the use of telemedicine in abortions. *See* Ex. A at ¶¶ 10, 43 (Mississippi Amended Complaint). Some of these laws have been in effect for years. The Mississippi plaintiffs claim that these laws are unconstitutional both individually and, when taken together, as a "cumulative[]" undue burden. *Id.* at ¶¶ 128-32.

Texas faces a similarly broad challenge to almost every state law and regulation covering abortion. *Whole Woman's Health Alliance v. Paxton*, No. 1:18-cv-00500-LY (W.D. Tex. filed June 14, 2018). The Texas plaintiffs have challenged over 60 individual laws and regulations, an entire chapter of administrative regulations, and

[1] No counsel for any party authored this brief, in whole or in part, and no person or entity other than amici contributed monetarily to its preparation or submission.

procedural rules of the Texas Supreme Court regarding judicial-bypass procedures for minors seeking abortions. *See* Ex. B at ¶¶ 78, 91, 105, 107, 116, 145, 153 (Texas Complaint). The plaintiffs challenged Texas's facility-licensing requirements, restriction on abortions performed by non-physicians, mandatory reporting requirements, regulation of medication abortion, the State's restriction on the use of telemedicine in abortions, informed-consent law, ultrasound requirement, 24-hour waiting period, parental-notice and consent requirements for minors, judicial-bypass procedures for minors, and criminal penalties for non-compliance with certain laws and regulations. As in Mississippi, some of these laws and regulations have been in effect for decades. The Texas plaintiffs included allegations that the challenged laws "[i]ndividually and collectively[] burden abortion access." *Id.* at ¶ 164; *see also id.* at ¶ 198. Texas filed a motion to dismiss. The district court held a hearing on the motion in early January 2019 but has not yet issued its decision.

In short, both the Mississippi and Texas lawsuits involve similar claims to this case. Yet if the federal courts in Mississippi and Texas adopt the same impermissible reasoning as the district court here, the States—and their taxpayers—will be unjustly subjected to the same burdensome and expensive litigation Louisiana now faces. Under existing precedent, the district court was required to dismiss plaintiffs' cumulative effects claim and hold these abortion-provider plaintiffs to the same pleading standards that other plaintiffs must meet. The States therefore urge the Court to grant the petition for a writ of mandamus.

ARGUMENT

A court may issue a writ of mandamus when (1) the right to the writ is clear and indisputable; (2) the party seeking the writ has no other adequate means to obtain relief; and (3) the issuing court is satisfied that the writ is appropriate under the circumstances. *In re Volkswagen of Am., Inc.*, 545 F.3d 304, 311 (5th Cir. 2008). A right to mandamus is clear and indisputable when a district court clearly abuses its discretion. *Id.* And a "district court abuses its discretion if it[] . . . relies on erroneous conclusions of law" or "misapplies the law to the facts." *Id.* at 310 (quoting *McClure v. Ashcroft*, 335 F.3d 404, 408 (5th Cir. 2003)). This Court "will grant mandamus relief when such errors produce a patently erroneous result." *Id.* The district court patently erred when it denied Louisiana's motion to dismiss an unprecedented claim foreclosed by this Court's precedent. It also patently erred when it allowed plaintiffs to skirt pleading standards, determining that it was "untenable" to hold abortion plaintiffs to the standards every other plaintiff must satisfy. Rule 8 has no abortion exception.

These errors also have significant consequences, not only for Louisiana, but also for Mississippi and Texas, which face similar lawsuits. If the Court does not intervene, Louisiana, and potentially Mississippi and Texas, will be forced to engage in lengthy and costly litigation on the taxpayer's dime to defend their comprehensive abortion regulatory systems against sweeping and impermissible challenges. This result cannot be alleviated through the normal appellate process, so there are "no other adequate means to attain the relief." *Id.* at 311. These extraordinary circumstances

warrant the extraordinary relief of a writ of mandamus, and the States urge the Court to grant the petition.

I. Louisiana Has A Clear And Indisputable Right To Mandamus.

Counts I and V of plaintiffs' amended complaint purport to bring a cumulative or collective burden claim. This novel claim presupposes that many of Louisiana's abortion regulations are, in fact, constitutional but, taken together, they amount to an undue burden. But binding precedent forecloses this theory. The district court wrongly permitted plaintiffs to challenge laws that are constitutional under established precedent despite the lack of adequate allegations to support such claims. By allowing plaintiffs to skirt settled requirements for pleading, the district court created an abortion exception to these rules, unlawfully expanding its own jurisdiction to decide nonjusticiable claims. The district court's order is a clear abuse of discretion, which provides Louisiana with an indisputable right to mandamus.

A. Plaintiffs' claims are foreclosed by precedent.

1. The district court's most obvious abuse of discretion is its disregard for this Court's precedent. While Louisiana's operative motion to dismiss was pending, this Court expressly rejected the district court's consideration of Louisiana's other abortion-related laws when assessing the constitutionality of the State's admitting-privileges law. *June Med. Servs. LLC v. Gee* (*June Medical I*), 905 F.3d 787, 810 n.60 (5th Cir. 2018), *reh'g en banc denied*, 913 F.3d 573 (5th Cir. 2019), *granting stay*, 139 S. Ct. 663 (Feb. 7, 2019), *pet. for cert. filed*, No. 18-1323 (U.S. Apr. 17, 2019). Relying on

Whole Woman's Health v. Hellerstedt and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, this Court held that "other abortion regulations [] unrelated to [the challenged law]" "have no bearing on [its] constitutionality." *Id.* If courts in this Circuit may not take other laws into account when assessing whether one law imposes an undue burden on women seeking abortion, plaintiffs cannot state an undue-burden claim based on the cumulative effects of dozens of unrelated laws. *See id.* [2]

The district court wholly ignored this authority; it never even acknowledged *June Medical I*. Instead, it concluded that "Plaintiffs have properly pled a cumulative effects cause of action under *Hellerstedt*." Pet. App. Ex. 18 p.20. But this Court rejected the idea that such a cause of action was created in *Hellerstedt*. *See June Medical I*, 905 F.3d at 810 n.60 (citing *Hellerstedt*, 136 S. Ct. 2292, 2300 (2016)). Under *June Medical I*, the district court was plainly wrong to assert that *Hellerstedt* created a new cause of action based on a cumulative undue burden. The district court's order is therefore "patently erroneous." *In re Volkswagen*, 545 F.3d at 310.

2. There is no plausible argument that *Hellerstedt* created a "cumulative effects" cause of action. The *Hellerstedt* plaintiffs did not challenge the constitutionality of an entire state abortion regulatory system. Rather, they challenged two specific Texas legal requirements—that abortion clinics be licensed as ambulatory surgical

[2] The petition for a writ of certiorari in *June Medical I* was filed after the district court's order was issued. While the petition argues that the Fifth Circuit's decision upholding Louisiana's admitting-privileges law was incorrect, it does not appear to argue that the Court should have considered Louisiana's other abortion-related laws in assessing the constitutionality of the admitting-privileges requirement. *See* Pet. for Writ of Certiorari, *June Medical Servs. LLC v. Gee*, No. 18-1323 (U.S. Apr. 17, 2019).

centers, and that abortion doctors have admitting privileges at a hospital within 30 miles of the clinic. *Hellerstedt*, 136 S. Ct. 2292. The Supreme Court analyzed *each* requirement to determine whether it was an undue burden, *id.* at 2310-18, and concluded that *each* was, *id.* at 2312 (admitting-privileges requirement), 2316 (ambulatory-surgical-center requirement); *see also id.* at 2299 ("*Each* [provision] places a substantial obstacle in the path of women seeking a previability abortion, each constitutes an undue burden on abortion access, and *each* violates the Federal Constitution." (emphases added) (citation omitted)).

The Court declined to go through the individual ambulatory surgical center regulations (which were not challenged by plaintiffs) and sever any that were unconstitutional, because it had already determined that the statute applying that regulatory regime to abortion clinics was facially unconstitutional. *Id.* at 2318-2320. Contrary to the district court's conclusion, this portion of *Hellerstedt* did not create a cumulative effects cause of action. Pet. App. Ex. 18 p.13 (quoting *Hellerstedt*, 136 S. Ct. at 2319-20). *Hellerstedt* involved application of an integrated set of facility regulations to abortion clinics all at once. The Court said nothing whatsoever about the cumulative impact of other abortion regulations. *Hellerstedt*, 136 S. Ct. at 2310-2318. *Hellerstedt* neither contemplated nor supported plaintiffs' novel claim that the collective weight of all of Louisiana's licensing requirements adopted incrementally over a number of years creates an unconstitutional undue burden.[3]

[3] In *Hellerstedt*, the district court had speculated on the possibility of cumulative burden, Pet. App. Ex. 5 p.9, and the plaintiffs urged the Supreme Court to recognize cumulative burdens, *see Hellerstedt*, 136 S. Ct. at 2340 (Alito, J., dissenting) (noting

Plaintiffs' claims are thus foreclosed by this Court's precedents and unsupported by anything in *Hellerstedt*. Louisiana is indisputably entitled to dismissal.

3. The district court's order further ignored binding precedent by permitting claims challenging valid laws to survive Louisiana's motion to dismiss. For example, plaintiffs challenge Louisiana's licensing requirement. Pet. for Writ of Mandamus 6. That claim is foreclosed by *Roe v. Wade*, which made clear that States may regulate and license the facilities in which abortions are provided in order to "insure maximum safety for the patient." 410 U.S. 113, 150, 163 (1973). This Court has held the same. *Women's Med. Ctr. of Nw. Hous. v. Bell*, 248 F.3d 411, 419 (5th Cir. 2001) (noting that "without violating the Constitution, the State could have required all abortion providers to be licensed"). Yet the district court denied Louisiana's motion to dismiss and allowed this claim to proceed to discovery.

The district court may not "usurp[] judicial power" by creating and permitting claims that defy binding precedent. *Schlagenhauf v. Holder*, 379 U.S. 104, 110 (1964) (internal citation omitted). Thus, the writ may be "appropriately issued." *Id.*; *see also In re U.S.*, 397 F.3d 274, 282 (5th Cir. 2005) (per curiam) (writ may be issued when a trial court "so clearly and indisputably abused its discretion as to compel prompt intervention by the appellate court"), *subsequent mandamus proceeding sub nom. United States v. Williams*, 400 F.3d 277 (5th Cir. 2005) (per curiam).

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plaintiffs' briefing repeatedly referred to the collective effect of the challenged laws). The Supreme Court declined that invitation and evaluated each challenged law individually. *Hellerstedt*, 136 S. Ct. at 2299, 2310.

B. There is no abortion exception to justiciability and pleading standards.

The district court also patently erred by refusing to hold plaintiffs to the same pleading standards that all other non-abortion plaintiffs must meet. Plaintiffs' cumulative-burden and individual claims flout basic pleading rules—yet the district court allowed them to proceed. The Court should correct that clear abuse of discretion.

Rule 8 enshrines a bedrock principle of civil procedure: "[t]o survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). To meet that "facial plausibility" standard, the plaintiff must "plead[] factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* If a claim is not recognized by law, it necessarily is not "plausible," and it is not possible to draw a "reasonable inference" of liability sufficient to deny a motion to dismiss. *Id.* Likewise, "[t]hreadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not" satisfy Rule 8. *Id.*; *see also Twombly*, 550 U.S. at 555.

The district court manifestly erred by not evaluating plaintiffs' claims under these pleading standards. In response to Louisiana's argument that plaintiffs failed to meet the pleading standards of Rule 8, the district court simply concluded that "Defendants are sufficiently on notice that Plaintiffs intend to cumulatively, and to the extent possible, individually, challenge the validity of the statutes and regulations that govern abortion providers in the State of Louisiana." Pet. App. Ex. 18 p.15. But

the Supreme Court requires more than "notice" that plaintiffs believe certain laws are unconstitutional—it requires factual allegations that make such claims plausible. *Iqbal*, 556 U.S. at 678; *Twombly*, 550 U.S. at 555 (2007). Indeed, the mere "notice" pleading the district court permitted was abolished decades ago. *See Iqbal*, 556 U.S. at 678-79.

The district court went out of its way to permit the plaintiffs' "threadbare recitals," *id.* at 678, to proceed. It praised plaintiffs for "*even go[ing] so far as to list in the Amended Complaint the specific statutes they deem objectionable*, and provide reasons, albeit repetitive ones, as to why the individual statute runs afoul of the rights of Plaintiffs and their patients." Pet. App. Ex. 18 pp.15-16 (emphasis added). But "a plaintiff's obligation to provide the 'grounds" of his 'entitle[ment] to relief' requires more than labels and conclusions." *Twombly*, 550 U.S. at 555. And as Louisiana noted, plaintiffs failed to plead even the most basic facts to support these challenges. For example, plaintiffs challenged Louisiana's law setting forth requirements for medical staffing, but never alleged they wish to hire someone who does not meet those requirements. *See* Pet. for Writ of Mandamus 11-12. They challenged Louisiana's physical facility requirements without pleading that their facility fails to meet these requirements, or that they wish to open another facility that does not meet these requirements. *See id.* at 11-13. It is not "plausible" to believe that women are

unconstitutionally burdened when abortion facilities are required to meet basic staffing and health and safety standards.[4] And insisting that plaintiffs plead basic facts stating a claim is not equivalent to requiring plaintiffs to prove their case at the pleading stage. *Twombly*, 550 U.S. at 556 ("Asking for plausible grounds . . . does not impose a probability requirement at the pleading stage; it simply calls for enough fact to raise a reasonable expectation that discovery will reveal evidence of illegal [conduct]." (footnote omitted)).

The district court further eroded the Rule 8 standard by permitting plaintiffs' cumulative-burden claim to proceed. *See supra* Part I.A. For the reasons set out above, that claim is foreclosed by precedent. *See id.* Yet the district court opined that if plaintiffs were not permitted to bring cumulative-burden claims, they "would be placed in an untenable position where they are forced to individually challenge many facially valid regulations, despite the fact that, taken together, such provisions may violate the directives of both *Planned Parenthood* [sic] and *Casey*." Pet. App. Ex. 18 p.15. The district court, thus, recognized that plaintiffs were seeking to enjoin "many facially valid regulations," but rather than dismiss those claims, the district court created a loophole around applicable pleading requirements. That reasoning violates

[4] Moreover, as Louisiana explains in its petition, plaintiffs' amended complaint is devoid of allegations that plaintiffs' patients would prefer clinics that are inadequately staffed or that lack health and safety measures—allegations that are necessary to support plaintiffs' claim of third-party standing. Pet. for Writ of Mandamus 31-32.

the core principle Rule 8 embodies: a plaintiff must plead *each* claim properly. Rule 8 contains no abortion exception that allows plaintiffs to skirt that basic requirement.

Plaintiffs seek to enjoin all of the challenged laws as facially unconstitutional—which requires them to prove that the laws pose a substantial obstacle to abortion for a large fraction of women, *see Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877, 895 (1992) (plurality op.)—without even pleading facts showing harm from each law or regulation being challenged. What is "untenable" is allowing plaintiffs to obtain what amounts to facial relief while skirting the requirements by pleading a massively overbroad cumulative burden claim. The district court's disregard for settled legal standards and willingness to create an abortion exception for the normal rules are patent error and justify mandamus.

II. Louisiana Has No Other Means For Relief, And Mandamus Is Appropriate Under The Circumstances.

It is no answer to say that Louisiana can obtain relief months or years from now through an ordinary appeal following final judgment. To get to that point, Louisiana will first be forced to expend significant resources and taxpayer dollars to defend a massively overbroad challenge to the State's entire abortion regulatory framework—even laws the district court suggested are facially constitutional.

The Court's action is further warranted to provide guidance to district courts in the amici States. The plaintiffs in the Texas and Mississippi cases have made similarly broad challenges, and their pleadings suffer many of the same core defects now before the Court. For example, in Mississippi, the plaintiffs explicitly include the same cumulative effects claim that this Court foreclosed in *June Medical I*. Ex. A at

¶ 148 (Mississippi Amended Complaint). In Texas, the plaintiffs insist they are challenging the numerous laws individually, but failed to include allegations supporting the claims.[5] They challenge a regulation requiring the sterilization of instruments, for example, but fail to plead why compliance with that regulation burdens their patients. *See* Ex. B at ¶ 78(b) (challenging the entirety of chapter 139 of title 25 of the Texas Administrative Code); 25 Tex. Admin. Code § 139.49 (requiring disinfection and sterilization of reusable medical devices in abortion clinics). In both Mississippi and Texas, plaintiffs challenge the States' requirement that only licensed physicians may perform abortions, but fail to allege that there are any qualified non-physicians who want to perform abortions at their clinics. Ex. A at ¶¶ 107-15 (Mississippi Amended Complaint); Ex. B at ¶ 78(a) (Texas Complaint).

These complaints embody a '"shotgun approach to pleadings,'" in which "the pleader heedlessly throws a little bit of everything into his complaint in the hopes that something will stick." *S. Leasing Partners, Ltd. v. McMullan*, 801 F.2d 783, 788 (5th Cir. 1986) (per curiam) (quoting *Rodgers v. Lincoln Towing Serv., Inc.*, 596 F. Supp. 13, 27 (N.D. Ill. 1984), *aff'd*, 771 F.2d 194 (7th Cir. 1985)). The Court should address this problem now. "[B]asic [pleading] deficienc[ies] should . . . be exposed at the point of minimum expenditure of time and money by the parties and the court." *Twombly*, 550 U.S. at 558 (second, third, and fourth alterations in original). As other courts have recognized, the costs of litigating cases like these are high, not

[5] *See* Transcript of Motion to Dismiss Hearing at 5, *Whole Woman's Health Alliance v. Paxton*, No. 1:18-cv-00500-LY (W.D. Tex. Jan. 4, 2019), ECF No. 66.

only for the States, but also for the judiciary. The Eleventh Circuit has warned about what happens when shotgun-type pleadings are permitted to survive a motion to dismiss:

> [A]ll is lost—extended and largely aimless discovery will commence, and the trial court will soon be drowned in an uncharted sea of depositions, interrogatories, and affidavits. Given the massive record and loose pleadings before it, the trial court, whose time is constrained by the press of other business, is unable to squeeze the case down to its essentials; the case therefore proceeds to trial without proper delineation of issues, as happened here. An appeal ensues, and the court of appeals assumes the trial court's responsibility of sorting things out. The result is a massive waste of judicial and private resources; moreover, "the litigants suffer, and society loses confidence in the court[s'] ability to administer justice."

Johnson Enters. of Jacksonville, Inc. v. FPL Grp., Inc., 162 F.3d 1290, 1333 (11th Cir. 1998) (footnote omitted) (quoting *Ebrahimi v. City of Huntsville Bd. of Educ.*, 114 F.3d 162, 165 (11th Cir. 1997)).

The States should not be forced to litigate such massive lawsuits when the claims are clearly barred by precedent and are not supported by plausible factual allegations. If plaintiffs cannot even plead facts showing that the challenged laws are an undue burden, they should not be allowed to subject States to onerous discovery and litigation. *See Associated Gen. Contractors of Cal., Inc. v. Cal. State Council of Carpenters*, 459 U.S. 519, 528 n.17 (1983) ("[A] district court must retain the power to insist upon some specificity in pleading before allowing a potentially massive factual controversy to proceed."). And at minimum, States should not be subjected to onerous discovery and forced to hire experts to defend laws challenged in claims that are barred by precedent.

Allowing the district court's clear abuse of discretion to go uncorrected will result in massive, complex, and expensive litigation to continue in Louisiana, and may also open the door for it to happen in the other Fifth Circuit States. These broad repercussions justify mandamus relief.

Conclusion

The Court should grant Louisiana's petition for writ of mandamus.

Respectfully submitted.

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Certificate of Service

I hereby certify that on May 24, 2019, this brief was filed electronically with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit using the CM/ECF system, which will send a notice of electronic filing to all parties.

/s/ Kyle D. Hawkins
Kyle D. Hawkins

Certificate of Compliance

This brief complies with: (1) the type-volume limitation of Federal Rules of Appellate Procedure 29(a)(5) and 21(d) because it contains 3,571 words, excluding the parts of the brief exempted by Rule 32(f); and (2) the typeface requirements of Rule 32(a)(5) and the type style requirements of Rule 32(a)(6) because it has been prepared in a proportionally spaced typeface (14-point Equity) using Microsoft Word (the same program used to calculate the word count).

/s/ Kyle D. Hawkins
Kyle D. Hawkins

EXHIBIT A

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI

JACKSON WOMEN'S HEALTH ORGANIZATION, on behalf of itself and its patients,

SACHEEN CARR-ELLIS, on behalf of herself and her patients,

Plaintiffs,

v.

MARY CURRIER, M.D., M.P.H., in her official capacity as State Health Officer of the Mississippi Department of Health,

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE,

KENNETH CLEVELAND, M.D., in his official capacity as Executive Director of the Mississippi State Board of Medical Licensure,

ROBERT SHULER SMITH, in his official capacity as District Attorney for Hinds County, Mississippi,

GERALD A. MUMFORD, in his official capacity as County Attorney for Hinds County, Mississippi,

and

WENDY WILSON-WHITE, in her official capacity as City Prosecutor for the City of Jackson, Mississippi,

Defendants.

Case No. 3:18-cv-00171-CWR-FKB

AMENDED COMPLAINT

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Plaintiffs Jackson Women's Health Organization ("JWHO" or the "Clinic"), on behalf of itself and its patients, and Dr. Sacheen Carr-Ellis, on behalf of herself and her patients (collectively, "Plaintiffs"), by and through their undersigned attorneys, bring this complaint against the above-named Defendants, their employees, agents, and successors in office, and in support thereof allege the following:

PRELIMINARY STATEMENT

1. Three weeks ago, Mississippi Governor Phil Bryant signed the latest in a long series of unconstitutional laws and regulations designed to restrict access to abortion within state borders. This new law—a ban on abortions after 15 weeks—is only the most recent salvo in what has been a 25-year legislative campaign to eliminate women's constitutional right to access abortion in Mississippi. The tactics and focus in this campaign have shifted over the past two decades, but the goal has always been clear: as stated by Governor Bryant, it is "ending abortion in Mississippi."

2. Mississippi has not been able to achieve its goal directly through an outright ban on abortion. The U.S. Supreme Court has prevented that by repeatedly re-affirming that women have a constitutional right "to choose to have an abortion before viability and to obtain it without undue interference from the State." *Planned Parenthood of Se. Pa.* v. *Casey*, 505 U.S. 833, 846 (1992). Instead, Mississippi has attempted to circumvent the Supreme Court's rulings by passing a series of targeted laws and regulations designed to choke off access to abortion in the state, primarily by decreasing the number of providers of abortion care, while at the same time delaying and misinforming women who manage to reach these providers.

3. The impact of these targeted laws and regulations on access to abortion in Mississippi is clear. In the early 1980s, there were several providers of abortion care operating in Mississippi, providing women access to legal and safe abortion. By 2004, there was only

one—Plaintiff Jackson Women's Health Organization. Today, 81 out of Mississippi's 82 counties have no provider of abortion care and 91% of women in Mississippi live in a county without a provider. The number of abortions provided annually in Mississippi has declined by almost two-thirds from 1991 to 2014. Nationally, women obtain abortions at almost four times the rate of Mississippi women.

4. While the decline in access to abortion care in Mississippi is stark, the state's legislative and regulatory efforts are not unique. Other states like Texas, Louisiana, Oklahoma, and Kansas—to name just a few—have also passed similar legislation and regulations aimed directly at providers of abortion care and their patients. None of these actions make abortions safer or improve women's health; instead, they are part of a national "step-by-step" legislative strategy by anti-abortion groups and their partners in state legislatures to eliminate abortion through a series of "accumulated" legislative victories—achieving incrementally what the Constitution prohibits states from doing outright. As one of the key anti-abortion groups in this effort has stated: "[t]hese legislative efforts are at the very heart of our work, and they are one of the keys to ending abortion in the United States." *The State of Abortion in the United States*, NATIONAL RIGHT TO LIFE COMMITTEE 4 (Jan. 2018), https://www.nrlc.org/communications/stateofabortion/.

5. These efforts to undermine women's constitutional rights have not gone unnoticed or unchallenged. In 2016, the U.S. Supreme Court struck down a set of laws in Texas similar to Mississippi's anti-abortion regime challenged here. In *Whole Woman's Health* v. *Hellerstedt*, the Supreme Court explained that Texas's anti-abortion laws were unconstitutional because the burdens they imposed on abortion access outweighed the meager benefits, if any, they conferred. 136 S. Ct. 2292, 2309–10 (2016). The district court in fact described the Texas

laws as "a brutally effective system of abortion regulation that reduces access to abortion clinics thereby creating a statewide burden for substantial numbers of . . . women." *Whole Woman's Health* v. *Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014), *aff'd*, 136 S. Ct. 2292 (2016).

6. Despite decades of Supreme Court precedent, including most recently *Whole Woman's Health*, Mississippi's efforts to eliminate access to abortion have proceeded largely unabated. For example, the State has imposed a byzantine series of unnecessary regulations on providers of abortion care. These regulations—also known as Targeted Regulation of Abortion Providers or "TRAP"—are unnecessary because they have nothing to do with women's health or providing safer abortion care. Without them, providers of abortion care would still be subject to the rules that govern office-based medical procedures in Mississippi that ensure such procedures are performed safely and in the patients' best interests. Instead, this TRAP regime is clearly designed to place substantial obstacles in the way of women seeking abortions. It also obstructs abortion access by imposing a cumulative regulatory burden on providers of abortion care that is simply not imposed on other medical practitioners who perform procedures with equal or higher complication rates.

7. Mississippi has also passed a series of laws that impermissibly burden women's access to abortion care by delaying, demeaning, and misinforming women who seek such care. Providers of abortion care are then forced to comply with these laws under threat of criminal penalty. Like the TRAP regime, these laws are not supported by any credible medical evidence that they benefit women's health; in fact, many are inconsistent with the standard of care recognized by the American Medical Association, the American College of Obstetricians and Gynecologists (or "ACOG"), and the American Academy of Family Physicians, among others.

8. Mississippi's latest legislative effort to restrict abortion access is House Bill 1510 ("H.B. 1510" or the "15 Week Ban"). This law includes a provision banning abortion after 15 weeks (with narrow exceptions), which is at least eight weeks before viability. Yet under decades of Supreme Court precedent, Mississippi cannot ban abortion prior to viability, regardless of what exceptions are provided to the ban. There is no question that the 15 Week Ban is unconstitutional under Supreme Court precedent.

9. The overall burden created by Mississippi's abortion regime is evident in the lack of Mississippi abortion providers and the statistics on access in the state. Hidden behind those numbers is the impact Mississippi's abortion laws have on individual women and families affected by the lack of access to abortion care. For example, Mississippi's arbitrary requirement that a woman must visit a clinic twice to obtain an abortion, when for any other comparable care she would have to go only once, means that many women must take additional time off from work, often forcing them to forego wages or perhaps even putting their employment at risk. And, because the only abortion clinic left in the state is in Jackson, a woman who wants to obtain abortion care in Mississippi may be forced to travel a significant distance to her two required appointments, trips that are particularly difficult for someone who does not own a car. The time these trips take may also necessitate additional childcare expenses and require explanations to a husband, partner, or other family member that put women at risk of domestic violence or worse. These burdens are considerable and real to many women who seek or would seek an abortion in Mississippi and, individually and collectively, they create a substantial obstacle to women who seek to exercise their constitutional right to access abortion care.

10. In 2016, in *Whole Woman's Health,* the Supreme Court found that the Texas abortion regime challenged in that case was unconstitutional because it created a

substantial obstacle to women seeking access to abortion care in the state. Mississippi's abortion laws and regulations are no different, and (like the Texas regime) have created a "brutally effective" system of abortion regulations that unduly burdens women and singles out providers of abortion care for arbitrary treatment in order to eliminate access to abortion in the state. Accordingly, Plaintiffs bring this action pursuant to both the Due Process and Equal Protection Clauses of the Fourteenth Amendment, seeking a declaration that the following Mississippi laws and regulations targeting providers of abortion care and their patients are unconstitutional, and seeking an injunction to prevent these unconstitutional laws from being enforced:

- The licensing scheme that subjects providers of abortion care to more burdensome regulations than healthcare providers who perform office-based procedures that have a similar or greater risk of complications, *see* Miss. Code Ann. § 41-75-1 *et seq.*; Miss. Admin. Code § 15-16-1:44.1.1 *et seq.* (the "TRAP Licensing Scheme");
- The requirement that women make two trips to a provider of abortion care that are separated by at least 24 hours in order to have an abortion, *see* Miss. Code Ann. § 41-41-33 (the "Mandatory Delay and Two Trip Requirement");
- The requirement that providers of abortion care recite false, misleading, and medically irrelevant information to their patients, or face criminal prosecution, *see* Miss. Code Ann. § 41-41-33 (the "Biased Counseling Law");
- The prohibition on qualified advanced practice clinicians ("APCs") providing abortion care, *see* Miss. Code Ann. § 41-75-1(f) (the "Physician Only Requirement"); and

- The prohibition on the practice of telemedicine that applies only in the context of providing abortion care, *see* Miss. Code Ann. §§ 41-41-33, 41-41-107 (the "Telemedicine Ban").

11. These laws and regulations lack any legitimate justification, medical or otherwise, and, individually and collectively, have the purpose or effect of placing substantial obstacles in the way of women seeking abortion care in Mississippi.

12. Plaintiffs also seek a declaration and injunction against H.B. 1510 because it bans abortion prior to viability, in violation of the liberty rights of Plaintiffs' patients, as guaranteed by the Fourteenth Amendment, and against Mississippi's Biased Counseling Law, which forces Dr. Carr-Ellis to recite to her patients a state-mandated message that falls outside accepted ethical standards and practices for informed consent practices in violation of her rights under the First Amendment. *See* Miss. Code Ann. § 41-41-33.

JURISDICTION AND VENUE

13. This action arises under the Constitution of the United States and the laws of the United States, including 42 U.S.C. § 1983. Thus, this Court has jurisdiction, pursuant to 28 U.S.C. § 1331, because it arises under federal law, and pursuant to 28 U.S.C. § 1343, because this action seeks to redress the deprivation of rights, privileges, and immunities secured by the Constitution of the United States.

14. Plaintiffs' action for declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2201 and 2202 and by Rules 57 and 65 of the Federal Rules of Civil Procedure.

15. Venue is proper under 28 U.S.C. § 1391(b) because a substantial part of the events giving rise to this action occurred in this District.

PARTIES

A. Plaintiffs

16. Jackson Women's Health Organization is a health care facility in Jackson, Mississippi that has been providing pregnancy testing, contraception counseling, and abortion care to women since 1996. Upon information and belief, it has been the sole licensed "Abortion Facility," *see* infra ¶ 58, in the State of Mississippi for more than a decade. The Clinic is a member of the National Abortion Federation, the professional association of abortion providers, and has been continuously licensed as an abortion facility by the Mississippi Department of Health (the "MDH") since it opened. The Clinic sues on its own behalf and on behalf of its patients.

17. Plaintiff Sacheen Carr-Ellis, M.D., M.P.H., is a board-certified obstetrician-gynecologist licensed to practice medicine in Mississippi, Alabama, Maryland, and Massachusetts. Dr. Carr-Ellis graduated with an M.D. from Albany Medical College and a master's in public health from Boston University. She completed her residency in obstetrics and gynecology at Boston University School of Medicine. Dr. Carr-Ellis has been providing reproductive health care since 1999. She has provided reproductive health care at the Clinic since 2014 and has been the Clinic's medical director since 2015. Dr. Carr-Ellis sues on behalf of herself and her patients.

B. Defendants

18. Defendant Mary Currier, M.D., M.P.H., is the State Health Officer of the Mississippi Department of Health. Among other things, Defendant Currier is responsible for supervising and directing all activities of the Department of Health, pursuant to Miss. Code Ann. §§ 41-3-5.1, 41-3-15(1)(c). Defendant Currier also has the authority to adopt and enforce regulations and standards with respect to abortion facilities, pursuant to Miss. Code Ann.

§ 41-75-13, and to revoke, suspend, or deny a license for violation of this or any law, pursuant to Miss. Admin. Code § 15-16-1:44.3.8. She is sued in her official capacity.

19. Defendant Mississippi State Board of Medical Licensure has the authority to suspend or revoke a physician's license to practice medicine in the State of Mississippi if the physician violates the 15 Week Ban, pursuant to H.B. 1510 § 1.6.

20. Defendant Kenneth Cleveland, M.D., is the Executive Director of the Mississippi State Board of Medical Licensure. He is responsible for the day-to-day operations of the Board, pursuant to Code Miss. R. 30-17-2645:1.2(F). He is sued in his official capacity.

21. Defendant Robert Shuler Smith is the District Attorney for Hinds County, Mississippi, which includes the City of Jackson. Defendant Smith has criminal enforcement authority for violations of the licensing scheme for abortion facilities, pursuant to Miss. Code Ann. § 41-75-26(1). He is sued in his official capacity.

22. Defendant Gerald A. Mumford is the County Attorney for Hinds County, Mississippi. Among other things, Defendant Mumford is responsible for prosecuting misdemeanors, pursuant to Miss. Code Ann. § 19-23-11(4). He is sued in his official capacity.

23. Defendant Wendy Wilson-White is the City Prosecutor for the City of Jackson, Mississippi. Defendant Wilson-White has the authority to prosecute misdemeanor offenses committed in the City of Jackson, pursuant to Miss. Code Ann. § 21-13-19. She is sued in her official capacity.

FACTUAL ALLEGATIONS

I. Mississippi Women Are Being Denied Their Constitutional Right to Access Abortion

24. In the half-century since it decided *Roe* v. *Wade*, 410 U.S. 113 (1973), the Supreme Court has, time and again, "reaffirm[ed] . . . the right of the woman to choose to have

an abortion before viability and to obtain it without undue interference from the State." *Casey*, 505 U.S. at 846. The Supreme Court has also repeatedly explained that both the right and the access it protects must be practical, not merely theoretical. As the Supreme Court recently reiterated, laws that "have the *purpose or effect* of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right." *Whole Woman's Health*, 136 S. Ct. at 2309 (quoting *Casey*, 505 U.S. at 878) (emphasis added). Thus, *even* where a statute serves a "valid state interest," if it also "has the effect of placing a substantial obstacle in the path of a woman's choice[, it] cannot be considered a permissible means of serving its legitimate ends" and is thus unconstitutional. *Id*. (quoting *Casey*, 505 U.S. at 877).

25. The Supreme Court has also repeatedly reaffirmed the importance of safe and legal abortion access, including its vital role in facilitating "[t]he ability of women to participate equally in the economic and social life of the Nation." *Casey*, 505 U.S. at 856. The availability of abortion enables women to decide whether to forego educational and economic opportunities due to unplanned pregnancy, whether to raise children with an absent or unwilling partner, and whether to accept the risk of carrying medically compromised pregnancies to term.

A. Mississippi Lags the Rest of the Nation in Access to Abortion

26. In 2014, there were 14.6 abortions per 1,000 women of reproductive age nationally, compared to 8.5 abortions per 1,000 women of reproductive age living in Mississippi. According to data collected by the Centers for Disease Control and Prevention ("CDC"), for those women living in Mississippi who did have an abortion, more than half obtained abortion care outside the state. Tara C. Jatlaoui *et al*., *Abortion Surveillance—United States, 2014*, 66 Morbidity and Mortality Weekly Report 20 (CDC Nov. 24, 2017), https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6624-H.PDF.

27. The lower abortion rate in Mississippi is not the result of fewer pregnancies overall or fewer unplanned pregnancies in the state. On the contrary, according to the CDC, approximately 62% of all pregnancies in Mississippi were unintended in 2010, compared to 45% nationally in 2011.[1] Of the unintended pregnancies, 22% resulted in abortion in Mississippi in 2010, whereas 42% resulted in abortion nationwide in 2011. Mississippi also has the highest or second-highest teen pregnancy rate in the country (depending on the year) – a rate almost double the national average.

28. The explanation for the substantially reduced rate of abortion in Mississippi lies in the legislature's concerted efforts over the past two-plus decades to limit access to abortion by regulating abortion and providers of abortion care out of existence. As a result of these efforts, Jackson Women's Health Organization is now the only clinic providing abortion care in the whole state, meaning that 81 out of Mississippi's 82 counties are without an abortion provider and 91% of Mississippi women live in a county where they cannot obtain an abortion. If the Clinic were to close, Mississippi women's constitutional right to access abortion care would be effectively eliminated within state borders.

B. Mississippi's Laws and Regulations Create a Significant Burden on Women's Access to Abortion in Mississippi

29. Mississippi's abortion laws and regulations create an undue burden on women who seek abortions in the state. For example, under Mississippi law, JWHO's clinicians are required to provide state-mandated biased information "orally and in person" to a patient seeking an abortion, after which the patient must wait 24 hours before returning to the Clinic a second time to obtain the abortion. Because this law forces women to make two trips to the

[1] The most recent year for which Mississippi data is available is 2010; nationally aggregated data is not available for 2011.

Clinic for an abortion some Mississippi women are forced to undertake the time and expense to travel over 600 miles or 10 hours to access abortion care at the Clinic. *See infra* ¶¶ 94–96. And the ban on telemedicine that only applies to medical care related to abortion means that women must make an unnecessary trip to Jackson to receive medical services that, for other health care, would be available through telemedicine. *See infra* ¶¶ 116–27. With access to telemedicine, the clinician could at least provide the state-mandated information to many of these patients over a monitor so the patients would not need to make two trips to the Clinic.

30. Mississippi's mandated burdens of delay and two separate trips to the Clinic are magnified for low-income women who, in the United States, make up 75% of the women who have abortions. For these women, travel of even short distances—30 to 50 miles, for example—can present significant obstacles as they must find or save money for the cost of transportation and other travel-related expenses and potentially take time off from work. Many must also find child care—not once but twice because of the Two Trip Requirement—as approximately two-thirds of the women who have an abortion at the Clinic already have at least one child.

31. These burdens are particularly acute in Mississippi, where almost a quarter of all working-age women (between the ages of 18 and 64) live below the poverty line—the highest percentage of women living below the poverty line in the nation—and many more qualify as low income. This means that many Mississippi women do not earn enough to cover their monthly expenses and do not have enough money at the end of each month to buy food and pay their bills. In fact, Mississippi is the most food-insecure state in the nation—more than one in five households do not consistently have the resources to put food on the table.

32. For women struggling just to feed their families, *any* additional costs created by Mississippi's abortion regime can make abortion care prohibitively expensive. And while the medical profession recognizes that abortion is an important component of women's health and reproductive health care, many women in Mississippi do not have insurance that covers abortion care. Health insurance purchased through the state exchange is prohibited from covering abortion care. *See* Miss. Code Ann. § 41-41-99(1). Public funds may not be used to pay for abortion, except when a woman's life is in danger or when she has reported being a victim of rape or incest both to law enforcement and to a physician who has certified the report. Thus, the majority of women must pay for abortion care out of pocket.

33. Mississippi's abortion laws and regulations also create a significant burden on women by delaying or preventing their access to abortion care. For example, due to the Mandatory Delay and Two Trip Requirement, some women must delay care in order to make the necessary logistical and transportation arrangements. Financial need may also create delays; indeed one of the most frequently cited reasons for delay is raising money for abortion care. These financial issues are linked not only to the lack of insurance coverage for abortion care, but also to the increased costs associated with travel and child care necessitated by Mississippi's abortion laws.

34. The burdens created by these delays are not only financial. Delay also increases health risks for women. For example, the risks of pregnancy, as well as the attendant physical and psychological burdens, increase the longer a pregnancy continues. The comparative risks associated with abortion procedures (while still very small) also increase as pregnancy advances. Finally, because some of the challenged laws work to delay access and others limit when a woman may seek care—most notably the 15 Week Ban—some Mississippi women are

delayed out of their ability to have the procedure at all and must carry a pregnancy to full term, with attendant psychological and physical risks. Others are forced to leave the state to access care while some resort to self-help methods, which can be unsafe or ineffective.

35. Mississippi's abortion regime also creates undue burdens on women by devaluing their opinions, autonomy, and decision-making power. Pregnant women are capable of deciding whether and when to end a pregnancy, taking into account all relevant factors. Forcing women to delay their access to abortion does not respect women's rights to make decisions about their own health; indeed, studies have shown that the majority of women seeking abortions would have preferred to obtain their abortions earlier than they did. Forcing women to carry a pregnancy to term promotes the stereotyped notions that motherhood is the preferred, natural, and proper state for women. It also suggests that women are not capable of making decisions about the timing, number, and spacing of children, but rather must be protected from the consequences of making decisions that others see as wrong.

II. Mississippi Has Intentionally Targeted Providers of Abortion Care and Tried to Eliminate Women's Ability to Exercise Their Constitutional Rights

36. The obstacles Mississippi has erected to women's access to abortion in the state are the result of a coordinated legislative strategy by Mississippi politicians and various anti-abortion groups dedicated to eliminating access to abortion throughout the country. The stated goal of this strategy is to eliminate abortion in the state altogether, including by forcing providers of abortion care to close, regardless of women's constitutional rights and regardless of the impact on women's health, women's autonomy to pursue their own goals and values, or women's ability to pursue educational and economic opportunities.

37. Mississippi has not yet been able to ban abortion outright, due to decades of U.S. Supreme Court precedent. But it has made clear that its intent is to recriminalize

abortion as soon as possible, and in 2007, Mississippi passed legislation imposing a criminal ban on all abortions and punishing clinicians with up to 10 years imprisonment for performing them, to be enforced if *Roe* v. *Wade* is ever reversed. *See* Miss. Code Ann. § 41-41-45.

38. In the meantime, Mississippi has enacted a web of laws and regulations that have undermined women's constitutional rights by choking off access to abortion in the state. This effect on access was not incidental. Over the years, Mississippi's legislators, including both the current and former Governor, have made clear statements that the purpose of these laws and regulations is to end legal abortion in Mississippi:

- "Rest assured that I am as committed as ever to ending abortion in Mississippi." Governor Bryant, speaking on the 42nd Anniversary of *Roe* v. *Wade* (Jan. 22, 2015), http://www.governorbryant.ms.gov/Pages/_Governor-Phil-Bryant-Comments-on-42nd-Anniversary-of-Roe-v-Wade.aspx.

- "Please rest assured that I also have not abandoned my hope of making Mississippi abortion free." Governor Bryant, Mississippi State of the State Address 2012 (Jan. 24, 2012), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2012/01/24/mississippi-state-of-the-state-address-2012.

- "We are very close to ending abortion in Mississippi, and I support all the pro-life bills that will do just that." Lieutenant Governor Tate Reeves, *quoted in* Elizabeth Waibel, *Reeves: "Very Close to Ending Abortion in Miss.,"* JACKSON FREE PRESS (Mar. 28, 2012, 4:53 p.m.), http://www.jacksonfreepress.com/news/2012/mar/28/reeves-very-close-to-ending-abortion-in-miss/.

- "I would love for Mississippi to become the first state in the nation to completely ban [abortions]." Senate Public Health Committee Chairman Alan Nunnelee, *quoted in* Holbrook Mohr, *Lawmakers Hope to Link Sonograms With Abortion; Believe Women Would Reconsider*, THE COMMERCIAL APPEAL (Jan. 21, 2007).

- "We've reduced those [abortion] numbers by over 60 percent adding various constitutionally allowable requirements on these (abortion) clinics. So our strategy is being successful." Senate Public Health Committee Chairman Nunnelee, *quoted in* Holbrook Mohr, *Abortion Ban Bill Heads; for Barbour's Signature*, THE COMMERCIAL DISPATCH (Mar. 9, 2007) (discussing S.B. 2391).

- "I said during my campaign that if we're ever going to end the tragedy of abortion, we have to start by changing hearts and minds one at a time. I think this is a good start." Governor Haley Barbour, Statement, *Governor Haley Barbour Caps Successful Pro-Life Agenda; Signs Four Bills* (May 6, 2004) (describing the slate of laws Governor Barbour signed, including a requirement that abortions after the first trimester could only be performed at hospitals and ambulatory surgical facilities that was later deemed unconstitutional).

39. This overriding intent was clearly articulated by Mississippi legislators in connection with H.B. 1390—the 2012 bill that, among other things, required all physicians who provided abortion care in Mississippi to have admitting privileges at a local hospital and that was deemed unconstitutional based on the Supreme Court's ruling in *Whole Woman's Health*—was signed into law. *See* Miss. Code Ann. § 41-75-1(f) (codification of H.B. 1390). For example:

- H.B. 1390 was part of "a movement . . . to try and end abortion in Mississippi." Governor Bryant, *quoted in* Roslyn Anderson, *Gov. Bryant Signs Abortion Bill*, MISS. NEWS NOW (2012), http://www.msnewsnow.com/story/17461039/gov-bryant-to-sign-abortion-bill.

- H.B. 1390 "should effectively close the only abortion clinic [Plaintiff JWHO] in Mississippi." Lieutenant Governor Reeves, *quoted in* Elizabeth Waibel, *Reeves: "Very Close to Ending Abortion in Miss."* JACKSON FREE PRESS (Mar. 28, 2012, 4:53 PM), http://www.jacksonfreepress.com/news/2012/mar/28/reeves-very-close-to-ending-abortion-in-miss/.

- "Our goal needs to be to end all abortions in Mississippi. I believe the admitting privileges bill gives us the best chance to do that." Lieutenant Governor Reeves, *quoted in* Faith Eischen, *Mississippi's Last Abortion Clinic to Remain Open, For Now*, IVN (July 11, 2012), https://ivn.us/2012/07/11/mississippi-last-abortion-clinic-to-stay-open/.

- "I think if this legislation causes there to be fewer abortions in Mississippi that is a positive result." House Public Health Committee Chairman Sam Mims V, who authored H.B. 1390, *quoted in* Ellen Ciurczak, *Abortion Debate Lives On*, HATTIESBURG AMERICAN (Mar. 25, 2012).

- "There's only one abortion clinic in Mississippi [JWHO]. I hope this measure shuts that down." State Senator Merle Flowers, *quoted in Mississippi Sole Abortion Clinic Sues Over New Law Aimed to Close Its Doors*, RTT NEWS (June 29, 2012, 1:28 PM),

http://www.rttnews.com/1915003/mississippi-sole-abortion-clinic-sues-over-new-law-aimed-to-close-its-doors.aspx.

- "We have literally stopped abortion in the state of Mississippi." State Representative Bubba Carpenter after passage of H.B. 1390, *quoted in* Karen McVeigh, *Mississippi Abortion Clinic's Forced Closure Challenged in Federal Court*, THE GUARDIAN (June 27, 2012, 5:46 PM), https://www.theguardian.com/world/2012/jun/27/mississippi-abortion-clinic-closure-challenged.

40. Many of Mississippi's efforts have been applauded—if not directed—by national anti-abortion groups that seek to eliminate abortion throughout the United States. Americans United for Life ("AUL"), the architects of much of the legislation challenged here, has praised Mississippi as an "excellent example of the cumulative effectiveness of the step-by-step enactment of" laws targeted at abortion. *Defending Life 2013*, AMERICANS UNITED FOR LIFE 55 (2013), http://aul.org/featured-images/AUL-1301_DL13%20Book_FINAL.pdf. In 2013, AUL noted that "[o]ver the past two decades, Mississippi has adopted more than a dozen [abortion-restricting] laws. As a result, abortions in the state have decreased by nearly 60 percent and six out of seven abortion clinics have closed." *Id*. The Mississippi affiliate of National Right to Life similarly boasted: "Working with elected officials at all levels of government, [Mississippi Right to Life] has been able to support the enactment of many pro-life statutes." *About Us*, MISSISSIPPI RIGHT TO LIFE, http://www.msrtl.org/about-us.html (last visited Apr. 4, 2018).

41. As with past laws and regulations, the intent behind Mississippi's most recent effort to limit access—the 15 Week Ban—is clear. In fact, a number of the same individuals who have previously expressed their support for ending abortion in Mississippi were also supporters of the 15 Week Ban. The Ban itself was the result of lobbying efforts by the Alliance Defending Freedom ("ADF"), a national advocacy group that is attempting to "put an end to the abortion industry," which not only drafted the bill, but specifically chose Mississippi

to enact it. Denise Burke, senior counsel at ADF, recently explained that the purpose of the 15 Week Ban is to end abortion outright by "baiting" a challenge to its constitutionality that would ultimately reach the Supreme Court and result *Roe* v. *Wade* being overturned. Arielle Dreher, *Reversing "*Roe*"; Outside Group Uses Mississippi as "Bait" to End Abortion*, JACKSON FREE PRESS (Mar. 14, 2018, 10:06 a.m.), http://www.jacksonfreepress.com/news/2018/mar/14/reversing-roe-using-mississippi-bait-end-abortion/. ADF deliberately chose Mississippi to be the first state to pass such a ban because, as Burke explained: "We have very carefully targeted states based on where we think the courts are the best, where we think the governors, the AGs and the legislatures are going to do the best job at defending these laws." ADF's lobbying efforts were so successful that three individual lawmakers—Representative Becky Currie, Senator Angela Hill, and Senator Joey Fillingane—introduced competing, *identical* versions, of ADF's work, though only Currie's bill, H.B. 1510, survived.

III. Mississippi's Laws and Regulations Target Women's Access to Abortion Care with No Corresponding Benefit

42. In *Whole Woman's Health*, the Supreme Court reiterated that "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right" to choose. 136 S. Ct. at 2309 (quoting *Casey*, 505 U.S. at 878). Moreover, "statute[s] which, while furthering [a] valid state interest, ha[ve] the effect of placing [] substantial obstacle[s] in the path of a woman's choice cannot be considered [] permissible means of serving [a state's] legitimate ends." *Id.* (quoting *Casey*, 505 U.S. at 877). Because access to abortion is "a constitutionally protected personal liberty," courts reviewing laws that regulate abortion must "consider the burdens a law

imposes on abortion access together with the benefits those laws confer"—including the "existence or nonexistence of medical benefits." *Id.*

43. Plaintiffs challenge three categories of Mississippi laws and regulations aimed at both providers of abortion care and women seeking abortions. The first is the separate TRAP Licensing Scheme for "Abortion Facilities," codified in part at Miss. Code Ann. § 41-75-1 *et seq.* The TRAP Licensing Scheme requires providers of abortion care to obtain and renew a particular health care facility license and to meet separate (albeit in some instances overlapping) sets of requirements established by both the Mississippi legislature and MDH via its implementing regulations in order to obtain or keep that license. *See* Miss. Admin. Code § 15-16-1:44.1.1 *et seq.* ("Minimum Standards of Operation for Abortion Facilities"); Miss. Admin. Code § 15-16-1:42.1.1 *et seq.* ("Minimum Standards of Operation for Ambulatory Surgical Facilities"). These laws and regulations are imposed on facilities providing abortion care but not on medical facilities offering similar—and in many cases much riskier—care and procedures. Together, the laws and regulations that make up this licensing system constitute Mississippi's TRAP Licensing Scheme.

44. The second category of laws Plaintiffs challenge are laws intended to delay, demean, and misinform women seeking abortion care. These laws, including the Mandatory Delay and Two Trip Requirement, Biased Counseling Law, and Telemedicine Ban, dictate the type of medical care providers can offer, and thus patients can receive, without regard to the standard of care or the patients' best interests. *See* Miss. Code Ann. § 41-41-31 *et seq.*

45. Third, the ban on abortions after 15 weeks from a woman's last menstrual period unlawfully strips women of their constitutional right to choose an abortion before viability.

A. Abortion Is Safe

46. Legal abortion is among the safest, most common medical procedures American women undergo. In fact, nearly one in four women in the United States (23.7%) will have had an abortion by the time she is 45 years old. Complication rates for abortion, including after 15 weeks from a woman's last menstrual period, are similar to or lower than for other outpatient procedures.

47. As the Supreme Court has recognized, abortion is a safe procedure with low risk of complications. *See Whole Woman's Health*, 136 S. Ct. at 2315–16. The leading medical authorities, including the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association have all concluded not just that abortion is an extremely safe medical procedure, but that it is actually one of the safest medical procedures performed in the United States.

48. In one of the most comprehensive studies to date, published in *Obstetrics & Gynecology*, the medical journal of ACOG, researchers found that major complications (defined as requiring hospital admission, surgery, or blood transfusion) from abortions occurred in less than one-quarter of one percent (0.23%) of cases.

49. Indeed, abortion is far safer than the alternative of carrying a pregnancy to term, particularly in Mississippi. Every year, 2% to 10% of pregnant women in the United States suffer from gestational diabetes mellitus, and approximately half of these women will go on to develop type two diabetes after pregnancy—a seven-fold increase in risk. According to the CDC, 144 in 10,000 women who gave birth in a hospital in the United States in 2014 experienced unexpected outcomes of labor and delivery that resulted in significant short- or

long-term consequences; such "severe maternal morbidity" disproportionately affects minority women.

50. The risk of death associated with childbirth is approximately 14 times higher than that associated with abortion, and every pregnancy-related complication is more common among women having live births than among those having abortions. This is especially true for women in Mississippi, which has the second-highest maternal mortality rate in the country. In Mississippi, the maternal mortality rate is more than *twice* the national average, at 39.7 pregnancy-related deaths per 100,000 live births between 2010 and 2012, the most recent data available. For African-American women in Mississippi, the maternal mortality rate is even worse: there were 54.7 deaths per 100,000 live births from 2011 to 2012. *Pregnancy-Related Maternal Mortality, 2011–2012*, MISSISSIPPI STATE DEPARTMENT OF HEALTH, http://msdh.ms.gov/msdhsite/_static/resources/5631.pdf (last visited Apr. 4, 2018). By contrast, according to the CDC, there were only 0.62 deaths per 100,000 legally induced abortions in the period 2008 through 2013, a fatality rate of 0.0006%. It is thus roughly 64 times more dangerous for a woman to give birth in Mississippi than it is for her to undergo a legal abortion.

51. Jackson Women's Health Organization performs abortions up to 16 weeks, 0 days as measured from the first day of a woman's last menstrual period. The two abortion techniques used at the Clinic are non-surgical—medication abortion and a procedure called vacuum aspiration ("aspiration"). Both are safe and effective.

52. Medication abortion is available up through 10 weeks from a woman's last menstrual period. Medication abortion is administered by oral consumption of two pills. Typically, a patient takes the first medication, mifepristone (distributed as Mifeprex), at the health facility, and then a second medication, misoprostol (distributed as Cytotec), up to 48 hours

later at home or another location of her choosing, where she passes the pregnancy in a process similar to a miscarriage.

53. Aspiration abortion, also referred to as "suction curettage" or "dilatation and curettage" ("D&C") is a straightforward outpatient procedure. It is sometimes referred to as "surgical" abortion, although no incision is made. Typically, the clinician uses a speculum—the same instrument used in a routine "pap" smear—and dilates the patient's cervix before inserting a thin tube through the cervix into the uterus, which is evacuated with gentle suction. The entire procedure typically takes about five to ten minutes. This procedure is identical in the contexts of abortion and miscarriage (spontaneous abortion).

54. Because there is no incision and instruments are introduced through a body cavity, aspiration abortion does not need to be performed in a sterile operating room. Nor does an aspiration procedure require general anesthesia. And while some clinicians may use a local anesthetic and/or minimal sedation that carry their own risks, JWHO only dispenses over-the-counter medications.

55. Complications associated with either medication or aspiration abortion are rare. Abortion is as safe as, if not safer than, many common outpatient procedures regularly performed in clinicians' offices, such as diagnostic hysteroscopy (to visualize the inside of the uterus), endometrial biopsy (to take a small tissue sample from the uterine lining), and *any* surgical or dental procedure requiring general anesthesia. A recent large study found that the prevalence of complications arising from first trimester aspiration abortion performed by a physician was 0.87%, and most are so mild that patients do not need hospital treatment. Ushma D. Upadhyay, PhD, MPH, *et al*., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 Obstetrics & Gynecology 175 (Jan. 2015). The prevalence of major

complications requiring treatment at a hospital was only 0.16% in first trimester aspiration performed by a physician. *Id.* A separate peer reviewed study designed to examine the impact on patient safety if aspiration abortions were performed by certified nurse practitioners, certified nurse midwives, and physician assistants found that the number of complications from abortions by these providers were "clinically equivalent" to abortions performed by physicians. Tracy A. Weitz, PhD, *et al.*, *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 Am. J. Pub. Health 454 (Mar. 2013). By comparison, vasectomy, another minor procedure frequently performed in a physician's office, has a prevalence of complications of 2%, more than double that of abortion, and a prevalence of major complications requiring hospitalization of 0.2% to 0.8%, up to five times higher than that of abortion.

56. Abortion is also much safer than the numerous other medical procedures performed in outpatient surgical facilities subject to significantly fewer regulations under Mississippi's laws and regulations than those imposed on facilities that provide abortion-care under Mississippi's TRAP Licensing Scheme. For example, abortion is lower risk and less complex than skin cancer removal, removal of pre-cancerous cells on the cervix through a Loop Electrosurgical Excision Procedure ("LEEP"), proctoscopy (scoping of the rectum, anus, or sigmoid colon), colonoscopy, surgical hernia repair, and large joint dislocations—all of which are routinely performed in an office-based, outpatient setting subject to significantly less regulation than the Clinic.

B. Mississippi's Abortion Licensing Scheme Targets Providers of Abortion Care

57. Mississippi has a set of regulations applicable to office-based surgical procedures, but abortion has been purposefully removed from this scheme and instead subjected to a separate set of unique and more burdensome regulations. This separate licensing scheme for

Abortion Facilities places arbitrary and unnecessary requirements on providers of abortion care that are not imposed on medical facilities that offer similar—and often more complex and riskier—care and procedures.

58. Mississippi first singled out "Abortion Facilities" as requiring special licensure and regulation by the Department of Health in 1991. *See* 1991 Miss. Laws Ch. 301 (S.B. 2884), *codified at* Miss. Code Ann. § 41-75-1 *et seq*. The new law defined "Abortion Facilities" as "a facility primarily organized or established for the purpose of performing abortions for outpatients," which "include[d] physicians' offices which [were] used primarily to perform elective abortions." Miss. Code Ann. § 41-75-1(f). The law exempts healthcare providers from licensing requirements if they perform less than 10 abortion procedures per month or 100 procedures per year, or if they are not a "separate identifiable legal entity from any other health care facility." *Id.* It is a criminal offense to operate an "Abortion Facility" without a license or with a suspended license in Mississippi. Miss. Code Ann. § 41-75-26(a).

59. Mississippi's abortion licensing scheme governs virtually every aspect of a clinic's operations, from its provision of medical care and counseling to its physical plant, administration, staffing, and recordkeeping. The licensing scheme imposes numerous arbitrary, onerous, and costly requirements that have no medical benefit, and/or that are not imposed on outpatient facilities performing procedures with a greater risk of complication.

1. Mississippi's TRAP Scheme Creates Substantial Obstacles to Abortion Access with No Medical Benefit

60. Mississippi's efforts to eliminate access to abortion in the State through medically unnecessary and burdensome regulations began in earnest in 2004. In 2004, Mississippi mandated that abortions performed at or beyond the first trimester could only be performed at a licensed Ambulatory Surgical Facility ("ASF") or hospital, a license JWHO could

not obtain for reasons unrelated to any interest in women's health, despite the fact that the Clinic had been safely performing abortions up to 16 weeks from a woman's last menstrual period for the eight years prior. That law was struck down as unconstitutional. *Jackson Women's Health Org.* v. *Amy*, No. CIV.A. 3:04CV495LN, 2005 WL 1412125, at *2 (S.D. Miss. June 14, 2005).

61. Undeterred, the next year Mississippi created the framework that exists today: all facilities providing abortion care must be licensed as either a Level I or Level II Abortion Facility, subject to all corresponding regulations, including the burdensome "Minimum Standards of Operation for Abortion Facilities." Miss. Code Ann. § 41-75-1(e), (h). When this law was passed, JWHO was the only abortion clinic in Mississippi, and thus the only clinic subject to these onerous regulations.

62. Under this licensing system, all facilities performing abortions after the first trimester are classified as Level I Abortion Facilities. In order to maintain a Level I Abortion Facility license, Level I facilities must satisfy the Abortion Facility requirements and must *also* satisfy the regulations applicable to Ambulatory Surgical Facilities, including the "Minimum Standards of Operation for Ambulatory Surgical Facilities." Miss. Code Ann. § 41-75-1(h). Other outpatient facilities performing procedures with equal or greater risk of complications are not subject to similar onerous requirements.

63. JWHO is licensed as a Level I Abortion Facility. JWHO is thus subject to all generally applicable health care regulations, all Abortion Facility laws and regulations—including the Minimum Standards of Operation for Abortion Facilities—*and* the Minimum Standards of Operation for Ambulatory Surgical Facilities. There are no Level II Abortion Facilities licensed in Mississippi.

64. Neither abortion by medication nor by aspiration is comparable to the many types of surgical procedures that can be performed at an Ambulatory Surgical Facility—which are broadly classified as procedures that are "more complex than office procedures performed under local anesthesia, but less complex than major procedures requiring prolonged postoperative monitoring and hospital care to ensure safe recovery and desirable results. General anesthesia is used in most cases." Miss. Code Ann. § 41-75-1(d). By contrast, the procedures performed by JWHO require *no* anesthesia and *no* incisions.

65. Physicians are allowed to perform procedures similar to those performed in Ambulatory Surgical Facilities, including procedures that require general anesthesia, in private physicians' offices classified as Level III Office Surgery facilities. *See* Miss. Admin. Code § 30-17-2635:2.6(A)(1). The requirements these facilities must satisfy are much less onerous than either Ambulatory Surgical Facilities or Level I or Level II Abortion Facilities, despite performing riskier procedures. *See* Miss. Admin. Code § 30-17-2635:1 *et seq.*

66. Abortion by medication or by aspiration is even safer than many Level I Office Surgery procedures, the least regulated of the outpatient procedure classifications. Level I Office Surgery includes procedures that may use local anesthesia, for example, hysteroscopies, proctoscopies, LEEP, laser cone of cervix, and paracentesis. Miss. Admin. Code § 30-17-2635:2.5.

67. Tellingly, the Mississippi regulations explicitly define dilation and curettage—the same procedure used to perform aspiration abortions, *see supra* ¶ 53—as a Level II Office Surgery procedure. Miss. Admin. Code § 30-17-2635:2.5. Yet, while JWHO, as a Level I Abortion Facility, is subjected to the burdens of both the Abortion Facility requirements and the Ambulatory Surgical Facility requirements, other physicians' offices that perform the

exact same procedure for purposes other than abortion (including in connection with miscarriages) are not.

68. In short, under the TRAP Licensing Scheme, providers of abortion care—in contrast to other clinics and medical providers performing substantially more risky procedures—are subject to licensing requirement which in turn subjects them to scores of medically unnecessary and burdensome regulations, the sole purpose of which is to regulate abortion access out of existence.

69. The chart below provides a stark illustration of examples of the unequal and burdensome requirements that Mississippi imposes on Level I Abortion Facilities that are not imposed on facilities that perform Level I or Level II Office Surgery:

	Level I Abortion Facility	**Level I Office Surgery**	**Level II Office Surgery**
License & Fee	License required subject to annual renewals to confirm compliance with licensing regulations and payment of $3,000 annual fee. Miss. Admin. Code §§ 15-16-1:44.3.1-3.	None	No fee. One-time registration with the Mississippi State Board of Medical Licensure. Miss. Admin. Code § 30-2635:2.2.
Inspection & Investigation Authority	"The licensing agency shall make or cause to be made such inspections and investigations as it deems necessary." Miss. Code Ann. § 41-75-17.	None	None
Reporting	Required to file monthly reports with MDH for each patient that include: ● Address; ● Marital status; ● Race; ● Education; ● Number of prior pregnancies; ● Number of previous live births; ● Prior pregnancy outcomes; ● Estimate of gestation; ● Date of last menstrual period; ● Type of procedure; and ● Additional procedures used. *See* Miss. Admin. Code § 15-16-1:44.5.1.	None	Only required to report potentially harmful or life-threatening episodes. Miss. Admin. Code §§ 30-2635:2.2-3.
Enforcement	Facility is subject to revocation of its license for any violation of the	None	None

	Level I Abortion Facility	Level I Office Surgery	Level II Office Surgery
	TRAP laws or rules and regulations thereunder. All violations, including by "careless, negligent or incautious disregard," are misdemeanors punishable by $1,000 fine/day. Miss. Code Ann. § 41-75-26.		
Medical Staff Organization & Personnel Requirements	Required to have: ● A physician medical director who is a certified OB/GYN responsible for all medical aspects of faculty programs; ● At least one registered nurse ("RN") per six patients, in addition to the director of nursing; and ● At least one physician and nurse present at all times when procedures are being performed. ● Employees must have an annual health examination to ascertain communicable diseases, a record of which must be maintained in his or her personnel file that is subject to inspection by MDH. Miss. Admin. Code § 15-16-1:44.11.2; Miss. Admin. Code § 15-16-1:44.10; Miss. Admin. Code 15-16-1:42.9; Miss. Code Ann. § 41-75-1.	None	Physician must be board certified or board eligible in the procedures performed in the office. Miss. Admin. Code § 30-2635:2.5.
Patient Transfer Agreement	Must have a written agreement with one or more physicians purportedly to ensure patients who have complications will be transferred to the physician's care. The physician must: ● Have full admitting privileges with an acute general hospital located within 30 minutes travel time of the abortion facility, and full credentials with the hospital; and ● Maintain his or her primary office location within 30 minutes' travel time of the abortion facility. Miss. Admin. Code § 15-16-1:44.12.1.	None	The surgeon must have a written transfer agreement from a licensed hospital within reasonable proximity. The agreement must include physician coverage of transferred patients if the physician does not have privileges at the hospital. Miss. Admin. Code § 30-2635:2.5.
Requirements for Medical Records	Must have a designated room or area at the facility for medical records. Patients' records must include:	Required to maintain "complete" records of each surgical procedure.	Required to maintain "complete" records of each surgical procedure and a log that includes a confidential

	Level I Abortion Facility	Level I Office Surgery	Level II Office Surgery
	● Identification, including full name, sex, address, date of birth, next of kin, and patient number; ● Admitting diagnosis; ● Preoperative history and physical examination pertaining to the procedure to be performed; ● Anesthesia reports; ● Procedure report; ● Laboratory and pathology reports and tests for RH Negative factor; ● Preoperative and postoperative orders; ● Discharge note and discharge diagnosis; ● Informed consent; and ● Nurses' notes. Miss. Admin. Code § 15-16-1:44.19.1, 2, 4.	Miss. Admin. Code § 30-2635:2.3.	patient identifier, the type of procedure, the type of anesthesia used, the duration of the procedure, the type of post-operative care, and any potentially harmful or life-threatening events. Must also maintain written informed consent from the patient reflecting the patient's knowledge of identified risks, consent to the procedure, and anesthesia provider. Miss. Admin. Code § 30-2635:2.3.
Prescriptions	All prescriptions must be signed by hand by the prescribing physician. Miss. Admin. Code §§ 15-16-1:44.25.1, 6.	Electronic prescriptions are permitted. Miss. Code Ann. § 41-127-1.	Electronic prescriptions are permitted. Miss. Code Ann. § 41-127-1.
Miscellaneous Authority	All other conditions are enforced in accordance with the best practices as interpreted by MDH. MDH reserves the right to review any and all records and reports of any Abortion Facility, as deemed necessary to determine compliance with these minimum standards of operation. Miss. Admin. Code § 15-16-1:44.32.1.	None	None

70. In addition to what is in the chart above, the regulations outlined in the Minimum Standards of Operation for Abortion Facilities impose regulations that are merely superfluous restatements of the basic standard of care and practice. Examples include mandating that Abortion Facilities have "adequate" linens or "sanitary" instruments, disposal of garbage and waste in a manner "designed to prevent the transmission of disease," provide "a safe and sanitary environment" that is "maintained to protect the health and safety of patients," and

maintain a smoke-free environment, all of which JWHO would do as a matter of basic standards of care. This level of micromanagement and regulation is not imposed on facilities that perform Level I or Level II Office Surgery, nor is there any medical justification for singling out providers of abortion care for such specific regulations given the exceedingly low complication rate of abortion.

71. Mississippi's TRAP Licensing Scheme is not medically justified nor does it serve to improve the safety of abortion care. If these requirements were intended to increase safety or improve medical care—in fact, if they were intended to do anything other than target providers of abortion care for unequal treatment in an effort to eliminate abortion access in Mississippi—similar requirements would also be imposed on other health facilities in Mississippi that perform medical procedures that carry equal or greater risk of complications.

72. The overall licensing scheme, including the many regulatory requirements it imposes, creates a burden on access to abortion. For example, the requirement that the Clinic have at least one registered nurse per six patients, forces the Clinic to hire RNs to perform tasks that do not require a nursing certificate, such as monitoring blood pressure or checking in patients, simply to maintain the arbitrary nurse-to-patient ratio mandated by the regulation. After the RN requirement took effect, the Clinic had to hire two additional RNs for roles that were previously fulfilled by medical assistants or licensed practical nurses to ensure the continuation of patient care. Due to the difficulty of hiring nurses, this requirement also creates scheduling issues which can limit access to abortion care. For example, the Clinic is forced to cancel patient appointments in order to comply with the nurse-to-patient ratio on days when one of JWHO's nurses is sick or unable to work. Likewise, the numerous recordkeeping requirements occupy

physicians and other medical staff with unnecessary and medically unjustified paperwork, instead of providing medical services to patients.

73. Similarly, because JWHO must satisfy the operating standards of an Ambulatory Surgical Facility, it is required to comply with regulations with no medical or safety rationale in the context of providing abortion care, and which are not required for Level I or Level II Office Surgery. For example, to satisfy the Ambulatory Surgical Facility standards, the Clinic is required to have a backup generator "to make life sustaining equipment operable in case of power failure," Miss. Admin. Code § 15-16-1:42.30.14, even though JWHO does not need or use any "life sustaining equipment," and there is no circumstance when this generator would be needed for this purpose.

74. The TRAP Licensing Scheme also creates a burden on access to abortion by limiting the number of abortions the Clinic can provide, for example due to the required registered nurse-to-patient ratios.

2. The TRAP Licensing Scheme Creates Unjustified Barriers to New Facilities

75. The TRAP Licensing Scheme also imposes significant costs and regulatory hurdles on prospective Level I or Level II Abortion Facilities that are not imposed on facilities that perform Level I or Level II Office Surgery. These additional burdens not only unlawfully target providers of abortion care, they also create a substantial obstacle to women's access to abortion in Mississippi by preventing any new clinics from opening, leaving JWHO as the sole provider. In fact, it has been more than 20 years since a new clinic has opened in Mississippi.

76. As an initial matter, any prospective provider of abortion care would be subject to the legal and regulatory provisions applicable to Level I and Level II Abortion

Facilities outlined in paragraphs 61 through 74, and their corresponding financial and administrative burdens. These alone present a significant barrier to any new clinic opening.

77. In addition, any new provider would be subject to an additional set of laws and regulations that govern the location, planning, and construction of any new facility willing to provide abortion care.

78. The chart below provides a comparison of just some of the regulations applicable to any prospective Abortion Facility, none of which are imposed on new facilities that perform Level I or Level II Office Surgery:

	Level I and Level II Abortion Facilities	Level I Office Surgery	Level II Office Surgery
Location Restrictions	Cannot be within 1500 feet of a church, school, or kindergarten. Must be within 30 minutes (Level II) or 15 minutes (Level I) of a hospital with an emergency room. MDH must approve the site before construction begins. Miss. Admin. Code § 15-16-1:44.31.1; Miss. Admin. Code § 15-16-1:42.30.1.	None	None
First Stage Submission—Preliminary Plans	Preliminary plans must be approved by MDH, and must include: ● Plot plans showing size and shape of entire site, location of proposed building and any existing structures, adjacent streets, highways, sidewalks, railroad, etc., all properly designated; size, characteristics, and location of all existing public utilities. ● Floor plans showing overall dimensions of buildings; location, size and purpose of all rooms; location and size of all doors, windows, and other openings with swing of doors properly indicated; and location of stairs, elevators, dumbwaiters, vertical shafts, and chimneys. ● Outline specifications listing the kind and type of materials. Miss. Admin. Code § 15-16-1:44.30.4.	None	None
Final Stage Submission—Working Drawings and Specifications	Final stage or working drawings and specifications must be approved by MDH prior to construction, and must include: (a) architectural drawings; (b) structural drawings; (c) mechanical drawings to include plumbing, heating, and air conditioning; (d) electrical drawings; and (e) detailed specifications.	None	None

	Level I and Level II Abortion Facilities	Level I Office Surgery	Level II Office Surgery
	The preparation of drawings and specifications must be executed by or under the immediate supervision of an architect registered in the State of Mississippi. Miss. Admin. Code §§ 15-16-1:44.30.5, 6.		
Structural Requirements	Corridors used by patients must be at least 5 (Level II) or 6 (Level I) feet wide. Exit doors must be no less than 36 (Level II) or 44 (Level I) inches wide. Minimum ceiling height must be 7 feet 8 inches. Miss. Admin. Code §§ 15-16-1:44.31.11, 16; Miss. Admin. Code §§ 15-16-1:42.30.10, 16.	None	None
Occupancy Restrictions	No part of an abortion facility may be rented, leased, or used for any commercial purpose, or for any purpose not necessary or in conjunction with the operation of the facility. Miss. Admin. Code § 15-16-1:44.31.12.	None	None
Emergency Equipment	Must have an emergency lighting system that will "adequately light corridors, operating rooms, exit signs, stairways, and lights on each exit sign at each exit in case of electrical power failure," Miss. Admin. Code § 15-16-1:44.31.14, and Level I facilities must have an emergency power generator to "make life sustaining equipment operable in case of power failure." Miss. Admin. Code § 15-16-1:42.30.14.	None	None
Materials Requirements	All draperies and cubicle curtains must be flame retardant. Miss. Admin. Code § 15-16-1:44.31.21. Carpet must have a flame spread rating of 75 or less and smoke density rating of 450 or less, or conform with paragraph 6-5, N.F.P.A. 101, Life Safety Code, 1981. Miss. Admin. Code § 15-16-1:44.31.20. Materials on walls and ceiling in corridors and rooms occupied by four or more persons must have a flame spread rating of 25 or less and a smoke density rating of 450 or less, and rooms occupied by less than four persons must have a flame spread rating of 75 or less and a smoke density rating of 450 or less. Miss. Admin. Code § 15-16-1:44.31.18.	None	None

79. The aspects of Mississippi's TRAP Licensing Scheme that are imposed on prospective abortion facilities are not medically justified nor do they serve to improve the safety of abortion care. If these requirements were intended to increase safety or improve medical care—in fact, if they were intended to do anything other than target prospective abortion providers for unequal treatment in an effort to eliminate abortion access in Mississippi—similar

requirements would be imposed on other prospective health facilities in Mississippi that provide medical care carrying equal or greater risk of complications, such as Level I or Level II Office Surgery facilities.

80. Many of these regulations impose significant financial burdens that prospective facilities performing Level I and Level II Office Surgery do not have to bear when planning and building clinics. For example, a prospective provider of abortion care would have to hire professionals to prepare mandatory, detailed architectural and engineering plans that he or she must submit to MDH. On information and belief, architects charge between $125 and $250 per hour to prepare the sort of detailed architectural and engineering plans required by the regulations.

81. A potential provider of abortion care must also build a facility that far exceeds the justifiable medical and operational needs of such care at great additional costs. For example, a Level I Abortion Facility would be required to build hallways that are six feet wide, and doorways 44 inches wide. On information and belief, this requirement would significantly increase costs for a prospective clinic.

82. Other requirements that, on information and belief, would significantly and unnecessarily increase construction costs include the requirement to install an emergency lighting system and the requirements to use specific flame retardant materials for curtains, wall coverings, and carpets.

83. Not a single one of these burdens or expenses is required to open a facility that performs Level I or Level II Office Surgery, despite the fact that it could perform riskier procedures than a Level I or Level II Abortion Facility.

84. Individually and collectively, these regulations create significant unnecessary barriers to the opening of additional clinics to provide abortion care. As a result, JWHO remains the only provider of abortion care in the state, which creates a substantial obstacle to Mississippi women's access to abortion.

C. Mississippi Has Created Unconstitutional Legal Barriers to Women's Access to Abortion

1. Mandatory Delay and Two Trip Requirement

85. Mississippi law requires that, unlike for other comparable medical procedures in the state, a woman has to make a second, unnecessary trip to her clinician's office in order to exercise her constitutional right to an abortion. In 1991, Mississippi passed H.B. 982, requiring a woman to delay her abortion by 24 hours after receiving "certain information regarding abortion and alternatives to abortion to be provided to the woman . . . [and] to provide penalties for violations." 1991 Miss. Laws Ch. 439 (H.B. 982). The law required a physician providing the abortion care, under threat of criminal penalty, to inform the patient at least 24 hours in advance of, among other things, "the probable gestational age of the unborn child," and to offer the patient materials that "describe the unborn child and list agencies that offer alternatives to abortion." *Id.*

86. A prior version of the law that similarly mandated a 24-hour delay period and required that physicians provide women with information on abortion alternatives and risks associated with abortion was rejected in 1990 by the Mississippi House Judiciary Subcommittee for its "very serious constitutional problems."

87. When H.B. 982 passed the House and Senate in 1991, it was vetoed by then-Governor Ray Mabus for constitutional concerns. However, the legislature overrode the Governor's veto the next day and the bill became law.

88. As written, the 1991 bill was ambiguous as to how and where the counseling had to take place. It was thus unclear whether a woman seeking an abortion would be forced to make two trips to a facility, at least 24 hours apart, or whether the prescribed information could be conveyed by phone.

89. In 1995, Mississippi's then-Attorney General issued an opinion that the statutorily prescribed "informed consent" material could be provided telephonically under the law. Office of the Att'y Gen., Opinion Letter, No. 95-0318, 1995 WL 328978 (May 5, 1995). This meant that women had to travel to a clinic only once, for the procedure itself, and could receive all other information by phone.

90. In direct response, the legislature passed S.B. 2817 in 1996, which, among other things, explicitly required the patient to travel to a clinic on two separate occasions, first, to receive the prescribed information "orally and in person" by the physician who was to perform the abortion and, at least 24 hours later, to obtain the abortion. *See* 1996 Miss. Laws Ch. 442 (S.B. 2817), *codified at* Miss. Code Ann. § 41-41-33. This law is still in effect, and a physician who fails to comply with this requirement is subject to criminal penalties of six months imprisonment, a $1,000 fine, or both. Miss. Code Ann. § 41-41-39. The combination of the 1991 and 1996 laws together created the "Mandatory Delay and Two Trip Requirement."

91. Under the auspices of "informed consent," the Mandatory Delay and Two Trip Requirement compels providers of abortion care, under threat of criminal prosecution, to tell their patients orally and in person, a state-mandated message that is outside accepted medical standards and practices for informed consent, and that they would not otherwise tell patients. It further compels patients to receive this false, misleading, and medically irrelevant information. Miss. Code Ann. § 41-41-33. For example, Dr. Carr-Ellis is compelled to tell her patients that

breast cancer is a risk associated with abortion, despite the fact that it is simply not true. *See id.* § 33(1)(a); *The Safety and Quality of Abortion Care in the United States*, A Consensus Study Report of the National Academies of Sciences, Engineering, and Medicine at 5-2 (The National Academies Press 2018), http://nap.edu/24950 (hereinafter "National Academies Consensus Report") (concluding that, based on a rigorous study of published research on potential long-term risks of abortion, "having an abortion does not increase a woman's risk of . . . breast cancer"). This state-mandated information is designed to obstruct and obscure the woman's decisional process and undermine her ability to make a factually informed decision. What is more, the Mandatory Delay and Two Trip Requirement is based on the notion that the woman needs to sit with this biased information for no less than 24 hours in order to make an "informed" decision.

92. This law also requires providers of abortion care to obtain patients' written confirmation that they have received this information prior to obtaining an abortion and maintain this documentation in patients' medical records. MDH is authorized to, and does, enforce this requirement by reviewing patients' unredacted medical records during unannounced inspections that are conducted at least annually. *Id.* §§ 41-41-33(1)(c), (2).

93. The State has not imposed similar two-trip or mandatory biased counseling requirements on any other comparable medical procedure in Mississippi in order for a patient to consent to that procedure. For example, although vasectomy includes both an incision and a higher risk of complication, no lag time is required in Mississippi for providers of vasectomy to obtain informed consent. Instead, whether a patient's medical decisions are sufficiently informed is entrusted to the reasonable judgment of the patient and physician.

94. The Mandatory Delay and Two Trip Requirement creates several substantial obstacles to a woman's right to access abortion care in Mississippi, particularly for

women who are poor or living in rural communities. In particular, the law imposes undue burdens of additional travel time, cost, and delays that create substantial obstacles to accessing abortion care.

95. Because the Clinic is the only provider of abortion care left in Mississippi, any woman who is seeking an abortion in the state must travel to the Clinic in Jackson not once, but twice. Many of the women who seek abortion care at the Clinic travel more than a hundred miles and several hours. The Mandatory Delay and Two Trip Requirement forces them to do so twice, doubling the time and expense of transportation, food, and potentially lodging. The logistical difficulty and expense of travelling twice is compounded for women who do not own a car since the State has so little public transit infrastructure that it ranks last in the nation for public transit usage. Of course, even women who do own cars have to incur gas and other expenses and contend with a long journey.

96. The Mandatory Delay and Two Trip Requirement also imposes other unnecessary costs and obstacles for patients, such as obtaining childcare twice for the two-thirds of the Clinic's patients with at least one child, and forcing women to take time off from work twice—not just losing those days' pay, but potentially jeopardizing their employment. The Mandatory Delay and Two Trip Requirement also forces women to twice explain their absence to husbands, partners, and employers, which could put some women at risk of physical, psychological, or economic harm. Collectively, these burdens of cost and travel time create a substantial obstacle to women seeking to access abortion care.

97. The Mandatory Delay and Two Trip Requirement also creates a substantial obstacle in terms of delay in accessing abortion care, which can increase health risks for women, reduce options for care or even prevent women from getting an abortion altogether.

98. By forcing women to come to the Clinic on two separate occasions, the Mandatory Delay and Two Trip Requirement creates a burdensome delay for a significant percentage of women who seek or would seek services from the Clinic. Some of the delay is caused by the reality of many women's situations when they cannot make two appointments on consecutive days or even in the same week due to employment or family concerns, for example.

99. Delay is exacerbated by the limited schedule for abortion care the Clinic is able to offer due to the cumulative effect of other of the challenged laws. *See infra* ¶¶ 114–15. At present, the Clinic is only able to see patients for abortion care approximately two to three days a week. This means that women who cannot make two appointments in the same week within this narrow window have to wait another week to have an abortion. And those who cannot fit a second appointment into the scheduling window during the next week may have to wait two weeks or more.

100. The delay created by the Mandatory Delay and Two Trip Requirement—and, in many cases by the interplay between the Mandatory Delay and Two Trip Requirement and the limited schedule forced on the Clinic by the TRAP regime as a whole—can prevent women from accessing a medication abortion. Medication abortion is available only through 10 weeks after a woman's last menstrual period. The delay created by the Mandatory Delay and Two Trip Requirement means that some women who seek a medication abortion in the ninth or even eighth week can no longer access a medication abortion because they are unable to return to the Clinic to obtain the abortion until after 10 weeks.

101. Likewise, because the Clinic only provides aspiration abortions through 16 weeks, 0 days from a woman's last menstrual period, women who make the first required trip to the Clinic in the 14th or 15th week may be forced by the Mandatory Delay and Two Trip

Requirement to leave the state to access abortion, or forego an abortion altogether. If the 15 Week Ban is allowed to go into effect, the window available to access an abortion in Mississippi will be narrowed further still, increasing the practical impact of the Mandatory Delay and Two Trip Requirement on limiting access to abortion.

102. This delay not only prevents some women seeking abortion from choosing the best method for her, or to have an abortion at all, it also increases the health risks for women who do obtain an abortion because abortion carries comparatively greater risk as pregnancy advances. *See supra* ¶ 34.

103. The Mandatory Delay and Two Trip Requirement also prevents the Clinic's physicians from appropriately allocating their time to providing the requested abortion care. Because the abortion regime requires Dr. Carr-Ellis to provide state-mandated biased counseling "orally and in person," she must do the first visit consultations during the two to three days per week she is at the Clinic. Currently, these consultations consume approximately one-third of the time Dr. Carr-Ellis is physically present in the Clinic – time that is then not available to provide abortion care to Clinic patients. If Dr. Carr-Ellis were consulting with patients for any other type of medical care in Mississippi, she could do so by telemedicine. *See* Miss. Code Ann. § 41-127-1.

104. Thus, if the Mandatory Delay and Two Trip Requirement did not exist, and there was no abortion-only exception to the state's highly permissive laws on the practice of telemedicine, *see infra* ¶¶ 116–20, Dr. Carr-Ellis could give women any required information outside of her limited Clinic hours and devote her time in the Clinic to providing women traveling to the state's sole remaining clinic with their constitutionally protected right to abortion care.

105. There are no countervailing benefits to the Mandatory Delay and Two Trip Requirement. It does not improve women's health nor is there any medical reason for it. In fact, abortion is the only medical care that is specifically targeted by Mississippi to require patients to travel to the medical provider's office not only once, but twice. Further, even if there was some benefit to a separate initial consultation, in every medical context other than abortion, Mississippi allows physicians to treat patients via "telemedicine" so that patients can access medical care, particularly specialized medical care that is not available in remote areas, without traveling great distances. *See infra* ¶ 116. Thus, even if the mandated 24-hour delay remained in effect, there is no valid reason that telemedicine could not be used for an initial consultation with respect to an abortion.

106. In short, the Mandatory Delay and Two Trip Requirement impermissibly targets providers of abortion care for more burdensome regulations and individually and collectively with the Telemedicine Ban, the Physician Only Requirement, and the TRAP Licensing Scheme, create an undue burden on women's constitutional right to access abortion in Mississippi.

2. Physician Only Requirement

107. At the same time the legislature passed the Mandatory Delay and Two Trip Requirement, it passed a requirement that "[a]bortions shall only be performed by physicians licensed to practice in the State of Mississippi." *See* 1996 Miss. Laws Ch. 442 (S.B. 2817), *codified at* Miss. Code Ann. § 41-75-1(f). The legislature later added a requirement that only physicians may "dispense[], administer[], or otherwise provide[] or prescribe[]" abortion-inducing medication. The violation of either law constitutes a misdemeanor. Miss. Code Ann. §§ 41-41-107(1), -111(1); *id.* § 41-75-26. In addition, other Mississippi laws contemplate that only physicians may provide certain aspects of pre-abortion care, and carry criminal penalties for

their violation. *See, e.g.*, *id.* § 41-41-33 (setting forth information that *the physician* who is to provide the abortion is required to give the patient at least 24 hours before the abortion, which includes the provision of biased counseling discussed *supra* ¶¶ 91–92); *id.* § 41-41-34 (pre-abortion requirements that must be fulfilled by *the physician* who is to provide the abortion, or a qualified person assisting that physician). Together, these laws form the "Physician Only Requirement."

108. Medication and aspiration abortions are regularly provided in other states by advanced practice clinicians ("APCs"), such as certified nurse practitioners, certified nurse midwives, and physician assistants.

109. Studies have found that this abortion care is just as safe when provided by APCs as when it is provided by physicians. National Academies Consensus Report at 3-7 to 3-9 (medication abortion); Tracy A. Weitz, PhD et al., *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 AM. J. PUB. HEALTH 454, 458–59 (2013) (aspiration abortion). Both the American College of Obstetricians and Gynecologists and the American Public Health Association, two leading associations of healthcare providers, have also recognized the safety of abortion provided by APCs. *See* American College of Obstetricians and Gynecologists, *Committee Opinion: Abortion Training and Education*, No. 612 (Nov. 2014), https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Abortion-Training-and-Education; American Public Health Association, *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants*, Policy No. 20112 (Nov. 1, 2011), https://www.apha.org/policies-and-

advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants.

110. Notwithstanding the demonstrated safety of medication and aspiration abortions provided by APCs, because of Mississippi's Physician Only Requirement, APCs are prohibited from providing abortions or certain forms of pre-abortion care in Mississippi.

111. There is no medical benefit or other reason to prevent APCs from providing this care. APCs in Mississippi regularly engage in patient care, in collaboration with or under the supervision of a licensed physician, that is comparable to first trimester abortions and that carries similar or greater risks of complications. For example, subject to approval by the Mississippi Board of Medical Licensure, APCs may be granted prescriptive authority for a full range of medications that, absent the Physician Only Requirement, would include the authority to prescribe medication abortion. *See* Miss. Code Ann. § 73-15-20 (prescribing authority for advanced practice registered nurses); Miss. Admin. Code § 30-17-2615:1.5 (prescribing authority for physician assistants). Certified Nurse Practitioners and Certified Nurse Midwives may also provide a wide range of women's health care, including treatment related to pregnancy, childbirth, family planning (including inserting and removing IUDs and other contraceptive implants), sexually transmitted infections, and other gynecological care.

112. Despite the drastically lower risk of complications associated with abortion as compared to childbirth, *see supra* ¶¶ 49–50, "females engaged solely in the practice of midwifery" *are completely exempt from laws requiring a license to practice medicine. See* Miss. Code Ann. §§ 75-25-1, -33.

113. The Physician Only Requirement creates a substantial obstacle to access to abortion care. Both ACOG and the American Public Health Association have identified a

shortage of abortion providers as a barrier to abortion access. *See Committee Opinion No. 612: Abortion Training and Education*, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (Nov. 2014), https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co612.pdf?dmc=1&ts=20170926T2329467312; *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants Policy No. 20112*, AMERICAN PUBLIC HEALTH ASSOCIATION (Nov. 1, 2011), https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants.

114. Because of the Physician Only Requirement, JWHO is unable to use APCs to provide abortion care and state-mandated biased counseling, and thus is only able to see patients for abortion care two to three days per week, when a physician is physically present in the Clinic. *See supra* ¶ 99. As with the Mandatory Delay and Two Trip Requirement, these scheduling constraints frequently result in patients being forced to wait one or two weeks between their initial visit to the Clinic and obtaining an abortion—which, in turn, increases the risk of complications and, in some cases, the cost of obtaining an abortion. *See supra* ¶¶ 99–102. In the most extreme cases, some women are forced to forego an abortion in the state altogether.

115. In short, the Physician Only Requirement impermissibly targets providers of abortion care for more burdensome regulations and individually and collectively with the Mandatory Delay and Two Trip Requirement, the Telemedicine Ban, and the TRAP Licensing Scheme, create an undue burden on women's constitutional right to access abortion in Mississippi.

3. Telemedicine Ban

116. "Telemedicine" is "the practice of medicine using electronic communication, information technology, or other means between a physician in one location and

a patient in another location." Miss. Admin. Code § 30-17-2635:5.1. In all medical contexts *except* abortion, Mississippi authorizes physicians to use telemedicine to provide consultations and treatment recommendations, including dispensing prescription medications, to patients. *See* Miss. Code Ann. §§ 41-41-33; 41-41-107(2) and (3); 41-127-1; Miss. Admin. Code § 30-17-2635:5.1.

117. As Mississippi has recognized, a face-to-face meeting is not necessary, or even important, to establish a physician-patient relationship or to provide "appropriate" medical treatment "if the technology is sufficient to provide the same information to the physician as if the exam had been performed face to face." *Id.* § 30-17-2635:5.5. Indeed, except in the provision of abortion care, Mississippi places "treatment recommendations made via electronic means" on equal footing with treatment in "traditional patient-provider settings" and provides that the two "shall be held to the same standards of appropriate practice." Miss. Code Ann. § 41-127-1.

118. In fact, telemedicine is routinely and successfully practiced in Mississippi, which has been recognized as a national leader in telemedicine. As Governor Bryant said, "Mississippi leads the nation in telemedicine and is one of only seven states to receive an 'A' rating from the American Telemedicine Association." Gov. Phil Bryant, *Governor Sets the Record Straight on Health Care*, CLARION LEDGER (Mar. 31, 2017), https://www.clarionledger.com/story/opinion/columnists/2017/03/31/governor-phil-bryant-sets-record-straight-health-care/99868700/.

119. For example, the University of Mississippi Medical Center uses telemedicine to diagnose potential concussion injuries for student athletes in real time (which may include a physical examination to determine the need for immediate medical attention, a

neurological examination, long- and short-term memory evaluations, and a sensory assessment, all via electronic means) in order to provide a return-to-play recommendation and treatment plan. *See Remote Concussion Evaluation*, UNIVERSITY OF MISSISSIPPI MEDICAL CENTER, CENTER FOR TELEHEALTH (2016), https://www.umc.edu/Healthcare/Telehealth/Files/th-concussion.pdf. No face-to-face interaction is necessary, even though the consequences of misdiagnosis can be severe and even fatal. *See* Charles H. Tator M.D., PhD, *Concussions and Their Consequences: Current Diagnosis, Management and Prevention*, 185 CAN. MED. ASSOC. J. 975, 977 (Aug. 6, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3735746/pdf/1850975.pdf.

120. Yet, at the same time Mississippi passed the law that opened the door to more widespread practice of telemedicine in 2013, it also passed the Telemedicine Ban, which banned the practice of telemedicine *solely* in the context of medication abortion, the intentional violation of which is a misdemeanor. 2013 Miss. Laws Ch. 551 (S.B. 2795), *codified in relevant part at* Miss. Code Ann. §§ 41-41-107, 41-41-111.

121. There is no medical justification for singling out abortion care and prohibiting the practice of telemedicine in the context of medication abortion. In fact, a recent consensus study report jointly prepared by the National Academies of Sciences, Engineering, and Medicine found no evidence that taking medication abortion requires the physical presence of a physician, and concluded that telemedicine medication abortion is just as safe as in-person medication abortion. *See* National Academies Consensus Report at 2-11, 2-27.

122. Further, medication abortion is extremely safe. Only one-tenth of one percent of women who used Mifeprex between 2000 and 2017 reported any adverse event. As a comparison, neurologists at St. Dominic Hospital in Jackson use telemedicine to diagnose stroke patients at hospitals hundreds of miles away based on CT scans or MRIs, and to prescribe

appropriate treatment, including whether to administer medication that is potentially life-saving for one type of stroke, and potentially fatal for the other. *See* Eric Wicklund, *Saving Lives With Telestroke Care*, MHEALTH INTELLIGENCE (Feb. 16, 2016), https://mhealthintelligence.com/news/saving-lives-with-telestroke-care. To the extent that complications do arise with medication abortion, because the second pill in the medication abortion regimen will be consumed outside of the office, almost all possible complications—however rare—will occur *after* the patients have left the provider's office.

123. Providing medication abortion via telemedicine also meets the standard of care recognized by ACOG and even the FDA label for Mifeprex. *Practice Bulletin: Medical Management of First-Trimester Abortion*, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS (Mar. 2014), https://www.acog.org/-/media/Practice-Bulletins/Committee-on-Practice-Bulletins----Gynecology/Public/pb143.pdf?dmc=1&ts=20180405T0157409810. ACOG also recognizes that medication abortion via telemedicine is of particular benefit to women who otherwise would have to travel great distances to access reproductive care. *Id.* And yet, the purported "legislative purpose" behind the Telemedicine Ban is to "[e]nsure that physicians meet the standard of care when giving, selling, dispensing, administering or otherwise providing or prescribing abortion-inducing drugs." Miss. Code Ann. § 41-41-103(2).

124. The Telemedicine Ban creates undue burdens for women seeking abortion by: (1) requiring the physician to physically examine the patient prior to administering medication abortion; (2) prohibiting anyone other than a physician from providing abortion-inducing drugs to patients; and (3) requiring that the abortion-inducing drug be administered "in the same room and in the physical presence" of the physician. Miss. Code Ann. § 41-41-107. Mississippi law also prohibits clinicians from providing the required pre-abortion biased

counseling via telemedicine, as it requires that such counseling be told to the patient "orally and in-person." Miss. Code Ann. § 41-41-33.

125. By preventing clinicians from providing care through telemedicine, the Telemedicine Ban forces women to bear the burden and cost of traveling back and forth to the Clinic to receive the pre-abortion biased counselling and/or medication abortion. *See supra* at ¶¶ 94–96. The Ban also leads to delays because women are required to be physically present at the Clinic twice, creating the need for multiple appointments. *See supra* at ¶¶ 98–99.

126. Further, without the Ban, the Clinic could increase the number of women able to receive care. For example, if Dr. Carr-Ellis could provide the mandatory consultations through telemedicine on days she is not physically present at the Clinic, she could focus on providing abortion care during the days she was physically present in the Clinic.

127. In short, the Telemedicine Ban impermissibly targets providers of abortion care for more burdensome regulation without conferring any benefit and, individually, and collectively with the Mandatory Delay and Two Trip Requirement, the Physician Only Requirement, and the TRAP Licensing Scheme, creates an undue burden on women's constitutional right to access abortion in Mississippi.

D. The Challenged Laws and Regulations Cumulatively Impose an Undue Burden on Women's Access to Abortion in Mississippi

128. Together, the challenged laws impose burdens that are exponentially greater than the burdens imposed by any single, individual challenged law operating in isolation. Thus, not only do the individual laws operate to limit access to abortion, but the cumulative impact of the challenged laws and regulations is to severely restrict and threaten ongoing availability of abortion care in Mississippi.

129. The challenged regime cumulatively imposes on women seeking abortion numerous, unnecessary restrictions that delay their access to care, increase the financial costs women bear to access abortion in the state, and increase health risks associated with otherwise very safe care.

130. Through demeaning and unnecessary laws, Mississippi's abortion restrictions discriminate against and stigmatize clinicians who offer abortion care, and the Mississippi women who seek it.

131. Mississippi's abortion restriction scheme threatens the existence of the sole remaining licensed abortion facility in the state by imposing multiple, overlapping restrictions with no benefit, and imposing expensive and time-consuming requirements on both providers and patients, which some patients may not be able to overcome, or may seek to overcome by traveling out of state to exercise their constitutionally protected right to access safe abortion care.

132. Defendants have the authority to subject Plaintiffs to a $1,000 penalty, six months in prison, or both, for each violation of some or all of the various provisions of Mississippi's abortion regime. *See* Miss. Code Ann. §§ 41-41-39; 41-41-111; 41-75-26. In addition, any provider of abortion care may have their license revoked for the violation of any of the laws or regulations outlined above. *See* Miss. Code Ann. § 41-75-26.

IV. The 15 Week Ban Unconstitutionally Deprives Women of the Right to an Abortion Before Viability

133. On March 19, 2018, Governor Bryant signed the 15 Week Ban into law, with an immediate effective date. Under the 15 Week Ban, "a person shall not intentionally or knowingly perform, induce, or attempt to perform or induce an abortion," if "the probable gestational age of the unborn human," which the physician is required to determine and

document prior to performing the abortion, is "greater than fifteen (15) weeks." H.B. 1510 § 1.4(b).

134. The only exceptions to the ban are if the woman is experiencing a medical emergency or in the case of a severe fetal abnormality. *Id*. The 15 Week Ban defines "medical emergency" as a physical condition or illness that makes it necessary to perform an abortion to save a woman's life or to prevent "a serious risk of substantial and irreversible impairment of a major bodily function." *Id.* at § 1.3(j). It defines a "severe fetal abnormality" as "a life-threatening physical condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb." *Id.* at § 1.3(h).

135. The 15 Week Ban defines "gestational age" or "probable gestational age" as "the age of an unborn human being as calculated from the first day of the last menstrual period," of the pregnant woman. *Id.* at § 1.3(f). Accordingly, the law bans abortions in Mississippi, with very limited exceptions, after 15 weeks from the last day of a woman's menstrual period.

136. The 15 Week Ban includes severe professional sanctions and civil penalties for violation. *Id.* at § 1.6. It provides that a physician "who intentionally or knowingly" violates the Ban "commits an act of unprofessional conduct and his or her license to practice medicine in the State of Mississippi shall be suspended or revoked pursuant to action by the Mississippi State Board of Medical Licensure." *Id.* at § 1.6(a).

137. Further, the 15 Week Ban gives enforcement authority to the Attorney General, stating that the "Attorney General shall have authority to bring an action in law or equity to enforce the provisions of this section on behalf of the Director of the Mississippi State Department of Health or the Mississippi State Board of Medical Licensure." *Id.* at § 1.7.

138. As discussed *supra* ¶¶ 99, 114, the Clinic typically provides abortion care two to three days per week and because of the Mandatory Delay and Two Trip Requirement, each of the Clinic's patients must make two separate visits to the Clinic, at least one full day apart. Because of patients' work and family commitments combined with the fact that the Clinic does not provide abortions every day of the week, Mississippi's abortion regime delays many patients by several days or more in obtaining an abortion. Thus, even patients who contact the Clinic and are able to schedule their first visit before 14 weeks, 6 days from their last menstrual period may not be able to return to the Clinic for an abortion before 15 weeks from their last menstrual period, again, as a direct result of the Mandatory Delay and Two Trip Requirement.

139. In 2017, 78 of the Clinic's patients obtained abortions after 14 weeks, 6 days from their last menstrual period, and who would fall within the 15 Week Ban.

140. The Clinic's patients seek abortions at this stage of pregnancy for a number of reasons, including difficulties or concerns related to financial, logistical, relationship, or other issues in their lives, family circumstances, and the health of the woman or the fetus. As is true nationwide, approximately two-thirds of the Clinic's patients already have at least one child.

141. In a normally progressing pregnancy, viability typically does not occur until at least 23 weeks from a woman's last menstrual period. Viability is a determination that must be made by a physician, and it will vary from pregnancy to pregnancy, depending on the health of the woman and the fetus. But there is no question that the 15 Week Ban prohibits abortion at least eight weeks before viability; no fetus is viable after only 15 weeks of pregnancy.

142. All Mississippi women seeking a pre-viability abortion after 15 weeks, except under the narrow exceptions provided in the 15 Week Ban, will be prohibited from obtaining abortions because of the Ban.

143. By prohibiting all abortions after 15 weeks from a woman's last menstrual period, except under the narrow exceptions listed, the Ban harms Plaintiffs' patients by denying access to pre-viability abortions and violating their constitutional rights. The exceptions to the Ban do not cure the constitutional violation.

144. The Ban presents Plaintiffs with an untenable choice: to face professional sanctions and civil penalties for continuing to provide abortions after 15 weeks from a woman's last menstrual period, or to stop providing the care their patients seek. These harms constitute irreparable harm to Plaintiffs and their patients.

145. Absent injunctive relief from this Court to enjoin the 15 Week Ban, Plaintiffs will be forced to turn away patients seeking pre-viability abortions, as described herein, or face the risk of substantial professional sanctions and civil penalties.

CLAIMS FOR RELIEF

COUNT I

SUBSTANTIVE DUE PROCESS—15 WEEK BAN

146. Plaintiffs reallege and hereby incorporate by reference paragraphs 1 through 145 above.

147. The 15 Week Ban bans abortion prior to viability, in violation of the liberty rights of Plaintiffs' patients, guaranteed by the Fourteenth Amendment of the United States Constitution.

COUNT II

SUBSTANTIVE DUE PROCESS—CUMULATIVE BURDEN

148. Plaintiffs reallege and hereby incorporate by reference paragraphs 1 through 147 above.

149. Mississippi's TRAP Licensing Scheme, Mandatory Delay and Two Trip Requirement, Biased Counseling Law, Physician Only Requirement, and Telemedicine Ban described above cumulatively violate Plaintiffs' patients' rights to liberty and privacy as guaranteed by the Fourteenth Amendment of the United States Constitution because they impose an undue burden on a woman's right to choose abortion before viability.

COUNT III

SUBSTANTIVE DUE PROCESS—INDIVIDUAL LAWS

150. Plaintiffs reallege and hereby incorporate by reference paragraphs 1 through 149 above.

151. The TRAP Licensing Scheme violates Plaintiffs' patients' rights to liberty and privacy as guaranteed by the Fourteenth Amendment of the United States Constitution because it imposes an undue burden on a woman's right to choose abortion before viability.

152. The Mandatory Delay and Two Trip Requirement violates Plaintiffs' patients' rights to liberty and privacy as guaranteed by the Fourteenth Amendment of the United States Constitution because it imposes an undue burden on a woman's right to choose abortion before viability.

153. The Biased Counseling Law violates Plaintiffs' patients' rights to liberty and privacy as guaranteed by the Fourteenth Amendment of the United States Constitution because it imposes an undue burden on a woman's right to choose abortion before viability.

154. The Physician Only Law violates Plaintiffs' patients' rights to liberty and privacy as guaranteed by the Fourteenth Amendment of the United States Constitution because it imposes an undue burden on a woman's right to choose abortion before viability.

155. The Telemedicine Ban violates Plaintiffs' patients' rights to liberty and privacy as guaranteed by the Fourteenth Amendment of the United States Constitution because it imposes an undue burden on a woman's right to choose abortion before viability.

COUNT IV

SUBSTANTIVE DUE PROCESS—ARBITRARY DEPRIVATION OF LIBERTY

156. Plaintiffs reallege and hereby incorporate by reference paragraphs 1 through 155 above.

157. Mississippi's TRAP Licensing Scheme, Mandatory Delay and Two Trip Requirement, Biased Counseling Law, Physician Only Requirement, and Telemedicine Ban described above, to the extent they subject Plaintiffs to requirements that only apply to providers of abortion care with no corresponding benefit, medical or otherwise, arbitrarily and irrationally deprive Plaintiffs of their substantive due process rights guaranteed by the Fourteenth Amendment of the United States Constitution.

COUNT V

EQUAL PROTECTION

158. Plaintiffs reallege and hereby incorporate by reference paragraphs 1 through 157 above.

159. Mississippi's TRAP Licensing Scheme, Mandatory Delay and Two Trip Requirement, Biased Counseling Law, Physician Only Requirement, and Telemedicine Ban described above, to the extent they subject Plaintiffs to more burdensome requirements than similarly situated providers of medical services, with no corresponding benefit, medical or

otherwise, arbitrarily and irrationally deprive Plaintiffs of their rights to equal protection guaranteed by the Fourteenth Amendment of the United States Constitution.

COUNT VI

FIRST AMENDMENT

160. Plaintiffs reallege and hereby incorporate by reference paragraphs 1 through 159 above.

161. The Biased Counseling Law compels Dr. Carr-Ellis to tell her patients, orally and in person, a state-mandated message that falls outside the accepted ethical standards and best practices for informed consent, and that she would not otherwise convey to her patients, violating Dr. Carr-Ellis's First Amendment rights not to speak.

PRAYER FOR RELIEF

Wherefore, Plaintiffs respectfully request that this Court:

1. Issue a declaratory judgment that H.B. 1510 is unconstitutional as applied to pre-viability abortions under the liberty clause of the Fourteenth Amendment to the United States Constitution and in violation of 42 U.S.C. § 1983;

2. Issue preliminary and permanent injunctive relief restraining Defendants, their employees, agents, and successors from enforcing H.B. 1510 as to pre-viability abortions;

3. Issue an order prohibiting Defendants, their employees, agents, and successors from bringing enforcement actions for pre-viability abortions performed while a Preliminary Injunction is in effect against H.B. 1510;

4. Issue a declaratory judgment that, individually and cumulatively, the TRAP Licensing Scheme, the Mandatory Delay and Two Trip Requirement, the Biased Counseling Law, the Physician Only Requirement, and the Telemedicine Ban are unconstitutional as applied and enforced by Defendants, under the due process and equal

protection clauses of the Fourteenth Amendment to the United States Constitution and in violation of 42 U.S.C. § 1983;

5. Issue a declaratory judgment that the Biased Counseling Law is unconstitutional as applied and enforced by Defendants, under the First Amendment to the United States Constitution and in violation of 42 U.S.C. § 1983;

6. Issue permanent injunctive relief restraining Defendants, their employees, agents, and successors from enforcing the TRAP Licensing Scheme, the Mandatory Delay and Two Trip Requirement, the Biased Counseling Law, the Physician Only Requirement, and the Telemedicine Ban;

7. Award Plaintiffs their reasonable costs and attorneys' fees pursuant to 42 U.S.C. § 1988; and

8. Grant such other or further relief as the Court deems just, proper, and equitable.

RESPECTFULLY SUBMITTED this 9th day of April, 2018.

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**Pro Hac Vice application to be submitted*
***Pro Hac Vice application submitted*

EXHIBIT B

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
AUSTIN DIVISION

WHOLE WOMAN'S HEALTH ALLIANCE; FUND TEXAS CHOICE; LILITH FUND, INC.; NORTH TEXAS EQUAL ACCESS FUND; THE AFIYA CENTER; WEST FUND; and BHAVIK KUMAR, M.D., M.P.H., Plaintiffs, v. KEN PAXTON, Attorney General of Texas, in his official capacity; CECILE YOUNG, Acting Executive Commissioner of the Texas Health & Human Services Commission, in her official capacity; JOHN W. HELLERSTEDT, M.D., Commissioner of the Texas Department of State Health Services, in his official capacity; SCOTT FRESHOUR, Interim Executive Director of the Texas Medical Board, in his official capacity; LARRY R. FAULKNER, PH.D., Interim Chancellor of the University of Texas System, in his official capacity; and DAVID ESCAMILLA, Travis County Attorney, in his official capacity and as representative of the class of all Texas county and district attorneys with authority to prosecute misdemeanor offenses, Defendants.	)	CIVIL ACTION CASE NO. 1:18-CV-00500

COMPLAINT

Plaintiffs, by and through their undersigned attorneys, bring this complaint against the above-named Defendants and their employees, agents, and successors in office, and in support thereof allege the following:

PRELIMINARY STATEMENT

1. Plaintiffs are nonprofit organizations and healthcare professionals who provide abortion care or facilitate access to abortion care. They bring this action pursuant to 42 U.S.C. § 1983 to challenge Texas laws that unduly burden abortion access.

2. In an unbroken line of precedent spanning more than four decades, the Supreme Court has held that the right to end a pregnancy is a fundamental component of the liberty protected by the Due Process Clause. *See, e.g.*, *Whole Woman's Health v. Hellerstedt*, ___ U.S. ___, 136 S. Ct. 2292, 2309-10 (2016); *Lawrence v. Texas*, 539 U.S. 558, 565, 573-74 (2003); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851-53 (1992); *Roe v. Wade*, 410 U.S. 113, 152-54 (1973). This right is critical to women's dignity, equality, and bodily integrity.[1] *See, e.g.*, *Casey*, 505 U.S. at 851-52, 856-57.

3. The Supreme Court has held that states may subject abortion to reasonable regulation, provided that it does not impose an undue burden on abortion access. In a recent decision, the Supreme Court clarified that a law fails this standard if it imposes burdens on abortion access that are not justified by proportional benefits. *See Whole Woman's Health*, 136 S. Ct. at 2300.

4. Texas has failed to respect these constitutional parameters.

[1] Most people with the capacity to become pregnant identify as women. Historically, both jurisprudence and public health data have focused on women when addressing reproductive rights and health. But there is an emerging recognition in the law and society more generally that not all people who may become pregnant identify as women. *See generally Glenn v. Brumby*, 663 F.3d 1312, 1316-19 (11th Cir. 2011) (holding, consistent with the weight of authority, that the Equal Protection Clause prohibits discrimination on the basis of "gender nonconformity") (collecting cases); Robin Marantz Henig, *How Science Is Helping Us Understand Gender*, National Geographic (2017), https://www.nationalgeographic.com/magazine/2017/01/how-science-helps-us-understand-gender-identity/. The Constitution protects the right of all individuals to end an unwanted pregnancy, regardless of gender identity.

5. Texas laws regulating abortion have proliferated over time. Pursuing an incremental strategy designed to chip away at abortion access, the State has layered restrictions on top of restrictions, steadily increasing the burdens faced by people seeking to end their pregnancies. Reasonable regulations have been superseded by unreasonable ones, increasing the cost and decreasing the availability of abortion care, while failing to provide added benefits. Abortion patients and providers now face a dizzying array of medically unnecessary requirements that are difficult, time-consuming, and costly to navigate—sometimes prohibitively so.

6. Plaintiffs ask the Court to strike down Texas' unduly burdensome abortion laws, returning the State to a regime of reasonable and medically appropriate abortion regulation.

JURISDICTION AND VENUE

7. Jurisdiction is conferred on this Court by 28 U.S.C. § 1331 because this case is a civil action "arising under the Constitution, laws, or treaties of the United States," and by 28 U.S.C. § 1343(a)(3) because this case seeks to redress the deprivation of federal constitutional rights under color of State law.

8. Venue is appropriate under 28 U.S.C. § 1391(b)(1)-(2) because the Defendants reside in this district and a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in this district.

PLAINTIFFS

9. Whole Woman's Health Alliance ("WWHA") is a Texas non-profit corporation committed to providing holistic reproductive healthcare. It operates a licensed abortion clinic in Austin, Texas, where it has provided high-quality abortion care since April 2017. It brings this lawsuit on behalf of itself and its patients.

10. Fund Texas Choice is a Texas nonprofit corporation that assists Texas residents in accessing abortion care. It provides direct financial assistance to individuals who must travel to access abortion care to cover the cost of transportation and accommodations. It works closely with clients to assess their needs and develop individualized access plans. Some of Fund Texas Choice's clients must travel out of state to obtain abortion care because the burdens created by Texas law make it too difficult to obtain that care in Texas. Fund Texas Choice covers one hundred percent of its clients' needs with respect to travel costs. But financial constraints prevent it from assisting every potential client in need. It had to cease funding clients in December 2017 because of insufficient revenue and could not resume funding clients until March 2018. Fund Texas Choice brings this lawsuit on behalf of itself and its clients.

11. Lilith Fund, Inc. ("Lilith Fund"), is a Texas non-profit corporation that assists Texans in exercising their fundamental right to abortion by removing barriers to access. It provides direct financial assistance to individuals residing in central and south Texas who want to end a pregnancy but cannot afford the full cost of an abortion procedure. Lilith Fund works closely with its clients to facilitate their access to abortion care. It recently hired a social worker to provide case management and doula services to its clients, as well as to facilitate a post-abortion support group. Lilith Fund has served over 10,000 clients since its founding in 2001. Unfortunately, financial constraints prevent it from serving every potential client who requests its assistance and from paying the full cost of an abortion procedure for each client that it does serve. Last year, Lilith Fund served nearly 1,500 clients. The average procedure cost for those clients was $1,162.74, and Lilith Fund's average grant amount was $193.82. In some cases, Lilith Fund's clients had to travel outside of Texas to obtain abortion care. Lilith Fund brings this lawsuit on behalf of itself and its clients.

12. North Texas Equal Access Fund ("TEA Fund") is a Texas nonprofit corporation serving people in northern Texas. It provides direct financial assistance to individuals who want to end a pregnancy but cannot afford an abortion procedure. TEA Fund works closely with its clients to facilitate their access to abortion care. It recently hired a social worker to support its clients through this process. Unfortunately, financial constraints prevent it from serving every potential client who requests its assistance and from paying the full cost of an abortion procedure for each client that it does serve. Last year, TEA Fund was able to offer financial assistance to approximately two-thirds of the individuals who requested assistance. It served 668 clients in all, providing an average grant of $256. In some cases, TEA Fund's clients had to travel outside of Texas to obtain abortion care. TEA Fund brings this lawsuit on behalf of itself and its clients.

13. The Afiya Center is a Texas nonprofit corporation with a mission to serve Black women and girls in Texas by transforming their relationship with their sexual and reproductive health through addressing the consequences of reproductive oppression. Using a reproductive justice framework, The Afiya Center works to assist Black women who are at high risk of contracting HIV/AIDS; reduce the maternal mortality rate among Black women; and facilitate Black women's access to abortion care. In connection with the latter work, The Afiya Center works one-on-one with clients in North Texas seeking abortion care. Its staff members conduct individualized assessments of clients' needs, provide clinic referrals and case management services, and follow up with clients periodically after their abortions. The Afiya Center also provides direct financial assistance to those who cannot afford the cost of obtaining abortion care. The Afiya Center brings this lawsuit on behalf of itself and its clients.

14. West Fund is a Texas nonprofit corporation that is committed to breaking down barriers to abortion care and helping people who want an abortion but do not have enough money

to pay for it. It provides direct financial assistance to individuals in West Texas who want to end a pregnancy but cannot afford the cost of an abortion procedure. Its trained volunteer case managers provide health center information and financial assistance to callers through its helpline. Unfortunately, financial constraints prevent the West Fund from paying the full cost of an abortion procedure for its clients. The average procedure cost its clients face is $2,200. West Fund typically provides grants of $150 to $350. In some cases, West Fund's clients must travel outside of Texas to obtain abortion care. West Fund brings this lawsuit on behalf of itself and its clients.

15. Bhavik Kumar, M.D., M.P.H., is a board-certified family medicine physician licensed to practice medicine by the State of Texas. Dr. Kumar serves as the Medical Director of WWHA's Austin clinic. He provides abortion care there and at other licensed abortion facilities in Texas. Dr. Kumar brings this lawsuit on behalf of himself and his patients.

DEFENDANTS

16. Ken Paxton, Attorney General of Texas, is sued in his official capacity. He has statutory authority to enforce certain of the laws challenged in this action. The Office of the Attorney General maintains its headquarters in Travis County.

17. Cecile Young, Acting Executive Commissioner of the Texas Health & Human Services Commission ("Health Commission"), is sued in her official capacity. She has statutory authority to enforce certain of the laws challenged in this action. The Health Commission maintains its headquarters in Travis County.

18. John W. Hellerstedt, M.D., Commissioner of the Texas Department of State Health Services ("Health Department"), is sued in his official capacity. He has statutory authority to enforce certain of the laws challenged in this action. The Health Department maintains its headquarters in Travis County.

19. Scott Freshour, Interim Executive Director of the Texas Medical Board ("Medical Board"), is sued in his official capacity. He has statutory authority to enforce certain of the laws challenged in this action. The Medical Board maintains its offices in Travis County.

20. Larry R. Faulkner, Ph.D., Interim Chancellor of the University of Texas System ("University"), is sued in his official capacity. The University has applied the limitations on abortion funding set forth in the General Appropriations Act of the 85th Legislative Session in an unconstitutional manner. The University maintains its headquarters in Travis County.

21. David Escamilla, Travis County Attorney, is sued in his official capacity and as representative of the class of all Texas county and district attorneys with authority to prosecute misdemeanor offenses.

FACTUAL ALLEGATIONS

I. BACKGROUND

A. Overview of Abortion Care in the United States

22. In the United States, the abortion rate has declined sharply since 2008. The reasons for this decline are not fully understood, but have been attributed to improved access to contraceptives, particularly long-acting reversible contraceptives ("LARCs") such as intrauterine devices and implants; as well as an increase in state laws that limit access to abortion care.

23. Nevertheless, abortion remains a common procedure. In 2014, the most recent year for which data are currently available, approximately 926,200 abortions were induced in the United States. Of those, 55,230 took place in Texas.[2]

[2] *See* Guttmacher Institute, *State Facts About Abortion: Texas* 1 (2018), https://www.guttmacher.org/sites/default/files/factsheet/sfaa-tx.pdf.

24. At current rates, approximately one in every four women in the United States will have an abortion by age 45.[3]

25. Most abortion patients are in their 20s (60%) and 30s (25%).[4]

26. Nearly 60% of abortion patients have previously given birth to a child.[5]

27. No racial or ethnic group comprises the majority of abortion patients. Nationwide, 39% of abortion patients are white; 28% are black; 25% are Hispanic; 6% are Asian or Pacific Islander; and 3% identify with other racial or ethnic classifications.[6]

28. Most abortion patients (62%) are religiously affiliated. The majority (54%) are Christians.[7]

29. Three-quarters of abortion patients in the United States are low-income, with nearly half living below the federal poverty level.[8]

30. Three methods of abortion are commonly used in the United States: medication abortion, aspiration abortion, and D&E abortion.

31. Medication abortion entails the administration of medications that end a pregnancy and cause the uterus to expel its contents. This method may be used from the start of pregnancy up to 10 weeks' gestation as measured by a woman's last menstrual period ("lmp").

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[3] Rachel K. Jones & Jenna Jerman, Population Group Abortion Rates and Lifetime Incidence of Abortions: United States, 2008-2014, 107 Am. J. Pub. https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042.

[4] Jenna Jerman, Rachel K. Jones & Tsuyoshi Onda, Guttmacher Institute, *Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008* 5 (2016), https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014.

[5] *Id.* at 7.

[6] *Id.* at 5.

[7] *Id.* at 7.

[8] *Id.* at 7.

32. Aspiration abortion entails the use of suction to empty the contents of the uterus. This method is typically used from 6 weeks lmp to 14-16 weeks lmp.

33. D&E abortion entails the use of suction and medical instruments to empty the contents of the uterus. This method is typically used beginning at 14-16 weeks lmp.

34. A fourth method of abortion—called induction—is used rarely in the United States. It entails the administration of medications to induce labor and delivery of a fetus, typically after 16 weeks lmp.

35. A Committee of the National Academies of Sciences, Engineering, and Medicine recently issued a Consensus Study Report on the Safety and Quality of Abortion Care in the United States after reviewing all available evidence.[9] It concluded that abortion in the United States is safe; serious complications of abortion are rare; and abortion does not increase the risk of long-term physical or mental health disorders.

36. The Committee assessed the quality of abortion care based on six factors: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. It concluded that the quality of abortion care depends to a great extent on geography. In particular, it found that "[i]n many parts of the country, state regulations have created barriers to optimizing each dimension of quality care."[10]

37. In a recent decision striking down a pair of Texas abortion restrictions, the U.S. Supreme Court likewise concluded that abortion is safe and complications from abortion are rare. *See Whole Woman's Health*, 136 S. Ct. at 2311, 2315. Indeed, the Supreme Court found that abortion is safer than many other procedures commonly performed in outpatient settings. *See id.*

[9] National Academies of Sciences, Engineering, and Medicine, *The Safety and Quality of Abortion Care in the United States* 1-16 (2018), https://doi.org/10.17226/24950.

[10] *Id.* at 10.

at 2315. It also recognized that unnecessary regulatory requirements may diminish the quality of care that patients receive. *See id.* at 2318.

38. Although abortion is safe throughout pregnancy, the risk, complexity, duration, and cost of abortion increase with gestational age.

39. The vast majority of abortions occur during the first trimester of pregnancy.

40. In 2014, 90% of abortions nationwide occurred during the first trimester.[11] For Texas residents, it was 87%.[12]

41. A recent study found that the following characteristics increase a person's likelihood of obtaining a second-trimester abortion: being Black; having less than a high-school degree; relying on financial assistance to pay for the procedure; living 25 or more miles from an abortion provider; and late recognition of pregnancy.[13]

B. Public Health and Safety in Texas

42. Texas is the second largest state in the nation by both population and area. Nearly 28 million people reside in Texas.[14]

43. About 11% of Texas residents are not U.S. citizens. Only two states have a higher percentage of non-citizen residents.

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[11] Rachel K. Jones & Jenna Jerman, *Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions*, 12 PLoS ONE 1, 5 (2017), http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0169969&type=printable.

[12] *Table 33 Selected Characteristics of Induced Terminations of Pregnancy Texas Residents, 2014*, Texas Department of State Health Services, https://www.dshs.texas.gov/chs/vstat/vs14/t33.aspx (Oct. 9, 2017).

[13] Jones & Jerman, *Characteristics and Circumstances of U.S. Women* at 9-11.

[14] Unless otherwise noted, the data in this section are derived from *State Health Facts,* Henry J. Kaiser Family Foundation, https://www.kff.org/statedata/ (last visited June 14, 2018).

44. Throughout Texas, arrests by Immigration and Customs Enforcement ("ICE") have increased, with increases in the northern part of the state up 76% in 2017.[15] Similarly, transfers from local police departments to ICE have risen as much as 60% in some counties.[16]

45. Overall, about 14% of Texas residents are living below the federal poverty level. Nearly 20% of Texas children are living below the federal poverty level.

46. About 20% of Black Texas residents and 20% of Hispanic Texas residents live below the federal poverty level, compared with 8% of White Texas residents.

47. Texas has the highest rate of uninsured people in the United States. More than four million Texas residents—including 750,000 children—lack health insurance. Nearly a quarter of women of reproductive age in Texas lack health insurance.[17]

48. According to the Texas Medical Association, the uninsured are up to four times less likely to have a regular source of healthcare and are more likely to die from health-related problems.[18]

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[15] Kristin Bialik, Pew Research Center, *ICE arrests went up in 2017, with biggest increases in Florida, northern Texas, Oklahoma*, http://www.pewresearch.org/fact-tank/2018/02/08/ice-arrests-went-up-in-2017-with-biggest-increases-in-florida-northern-texas-oklahoma/ (Feb. 8, 2018).

[16] Julian Aguilar, *Report: After Donald Trump took office, ICE transfers jumped 60 percent in most populous Texas county*, Texas Tribune, May 8, 2018, https://www.texastribune.org/2018/05/08/harris-county-ICE-arrests-increase-donald-trump/ (last visited June 14, 2018).

[17] Kinsey Hasstedt & Adam Sonfield, Guttmacher Institute, *At It Again: Texas Continues to Undercut Access to Reproductive Healthcare*, https://www.guttmacher.org/article/2017/07/it-again-texas-continues-undercut-access-reproductive-health-care (July 18, 2017).

[18] *The Uninsured in Texas*, Texas Medical Association, https://www.texmed.org/uninsured_in_texas/ (last visited June 14, 2018).

49. Texas had an unintended pregnancy rate of 56 per 1,000 women aged 15-44 in 2010, the last year for which data are currently available. Only eight states had higher rates of unintended pregnancy.[19]

50. In 2013, the teen pregnancy rate in Texas was 58 per 1,000 women aged 15-19. Only two states had higher rates of teen pregnancy.[20]

51. Texas has a high rate of maternal mortality. Although it is difficult to ascertain the precise rate because of the State's poor recordkeeping, in 2012, there were at least 56 maternal deaths giving rise to a maternal mortality rate of at least 14.6 per 100,000 live births.[21]

52. Black women are disproportionately affected by maternal mortality in Texas. In 2012, the maternal mortality rate for Black women in Texas was at least 27.8 per 100,000 live births, nearly double the statewide average.[22]

53. In 2014, 2,320 infants died in Texas before their first birthday. Sixty-six percent of them were Black or Hispanic.[23]

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[19] Kathryn Kost, Guttmacher Institute, *Unintended Pregnancy Rates at the State Level: Estimates for 2010 and Trends Since 2002* 8 (2015), https://www.guttmacher.org/sites/default/files/pdfs/pubs/StateUP2010.pdf.

[20] Kathryn Kost, Issac Maddow-Zimet & Alex Arpaia, Guttmacher Institute, *Pregnancies, Births and Abortions Among Adolescents and Young Women in the United States, 2013: National and State Trends by Age, Race and Ethnicity* 35-36 (2017), https://www.guttmacher.org/sites/default/files/report_pdf/us-adolescent-pregnancy-trends-2013.pdf.

[21] Meagan Flynn, *Texas's Maternal Mortality Rate Was Unbelievably High. Now We Know Why.*, Washington Post, April 11, 2018, https://www.washingtonpost.com/news/morning-mix/wp/2018/04/11/texas-maternal-mortality-rate-was-unbelievably-high-now-we-know-why/?utm_term=.be6680814fd2.

[22] *Id.*

[23] *Table 29 Summary of Infant Deaths by Age, Race, Ethnicity and Sex, 2014*, Texas Department of State Health Services, http://www.dshs.texas.gov/chs/vstat/vs14/t29.aspx (August 3, 2016).

54. In recent years, family violence has been on the rise in Texas. According to the Texas Department of Public Safety, in 2016, there were 196,564 incidents of family violence in Texas. That is a 10.4% increase from 2011.[24]

55. Sexual assault has remained relatively constant in Texas in recent years. There were 18,349 incidents of sexual assault in Texas in 2016. That is a 1.4% increase from 2011.[25]

C. Decline in the Accessibility and Affordability of Reproductive Healthcare

56. The accessibility and affordability of reproductive healthcare services have been declining in Texas as a result of the laws challenged here and other governmental policies.

57. In 2013, a law requiring physicians who perform abortions to have hospital admitting privileges caused more than half of the facilities providing first-trimester abortion care in Texas to stop providing that care. Prior to the enactment of the law, more than forty facilities provided first-trimester abortion care in Texas. After the law took effect, fewer than twenty facilities were able to provide such care. Many of the others were forced to close.

58. Although the Supreme Court ultimately struck down the admitting-privileges requirement, *see Whole Woman's Health*, 136 S. Ct. at 2300, few of the clinics that had closed were able to reopen. Too much time had passed—staff members had been let go; buildings and equipment had been sold; doctors had moved on.

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[24] *Compare* Texas Department of Public Safety, *Crime in Texas 2016* 36 (2017), http://www.dps.texas.gov/crimereports/16/citCh5.pdf *with* Texas Department of Public Safety, *Crime in Texas 2011* 35 (2012), http://www.dps.texas.gov/crimereports/11/citCh5.pdf.

[25] *Compare* Texas Department of Public Safety, *Crime in Texas 2016* 51 (2017), http://www.dps.texas.gov/crimereports/16/citCh7.pdf *with* Texas Department of Public Safety, *Crime in Texas 2011* 50 (2012), http://www.dps.texas.gov/crimereports/11/citCh7.pdf.

59. The vast array of medically unnecessary legal requirements governing abortion care in Texas serves as a barrier to new providers entering the field. As a result of these laws, few new clinics have opened to replace the ones that closed.

60. WWHA's Austin clinic is a notable exception. Last year, WWHA opened a new abortion clinic at a site where one had closed as a result of the admitting-privileges requirement. Opening that clinic required the investment of a tremendous amount of time, effort, and resources by WWHA—a charitable organization with a mission to serve the needs of people seeking abortion care.

61. For the average healthcare professional who is qualified and willing to provide abortion care, the demands of Texas law make opening an abortion clinic or otherwise providing abortion care prohibitively difficult.

62. Medically unnecessary legal restrictions that limit the pool of abortion providers ultimately cause people who need abortion to suffer. Healthcare professionals can provide other services, but someone who does not want to be pregnant has few options. That person must find a way to reach a lawful provider, face the life-altering consequences of carrying a pregnancy to term, or take actions outside of the law to end the pregnancy.

63. The availability of second-trimester abortion care is even more limited in Texas. A 2003 law requires abortions to be performed in ambulatory surgical centers or hospitals beginning at 16 weeks' gestation (18 weeks lmp). There are only a handful of such facilities willing to provide abortion care absent exceptional circumstances, and they are all located in the Texas's largest metropolitan areas: Houston, Dallas-Fort Worth, Austin, and San Antonio.

64. A 2013 law bans abortion beginning at 20 weeks' gestation (22 weeks lmp). As a result, people delayed in reaching an abortion provider beyond that point may not lawfully end their pregnancies in Texas.

65. At the same time that it has diminished the accessibility and affordability of abortion care, Texas has also taken steps to diminish the accessibility and affordability of contraception.

66. In 2011, Texas slashed its family planning budget by two-thirds, resulting in sharply diminished access to contraception by low-income individuals.

67. In 2013, Texas restored some of the funding, but excluded organizations that are affiliated with abortion providers from participating in its family planning program. As a result, many of the State's most experienced family planning providers are unable to serve low-income communities, and many in those communities do not know where to go to access affordable contraception.

II. THE CHALLENGED LAWS

68. Plaintiffs challenge Texas laws that fall into five categories: targeted regulation of abortion providers ("TRAP"); laws that deny abortion patients the benefits of scientific progress; mandatory disclosure and waiting-period laws; parental involvement laws; and criminal penalties. Plaintiffs also challenge the General Appropriations Act's limitation on abortion funding as applied by the University of Texas System to prohibit students from completing internships and field placements with organizations that facilitate abortion access.

A. Targeted Regulation of Abortion Providers (TRAP)

69. TRAP laws single out abortion providers for regulatory requirements that are different and more burdensome than those governing other healthcare providers.

70. The requirements imposed by these laws are not based on differences between abortion and other medical procedures that are reasonably related to patient health.

71. Texas enacted its first TRAP law in 1985. It required abortion facilities to become licensed and meet minimum standards set by the then Texas Board of Health. *See* 1985 Tex. Gen. Laws 3173-75. The licensure requirement did not apply to physician's offices unless they were used "primarily" for abortion care. *Id.* at 3174. The original TRAP law also required abortion providers to report certain data about the abortion procedures they performed to the then Texas Department of Health on an annual basis. *Id.* at 3173.

72. Since 1985, Texas has amended this law numerous times, incrementally increasing the burdens on abortion access each time.

73. For example, in 1999 and again in 2003, Texas narrowed the exemption for physician's offices. *See* 2003 Tex. Gen. Laws 671, 1999 Tex. Gen. Laws 4820-21. As a result of these amendments, any medical office that performs more than fifty abortions in a twelve-month period must be licensed as an abortion facility.

74. In 2003, Texas added a requirement that, beginning at 16 weeks' gestation (18 weeks lmp), abortions must be performed in a hospital or ambulatory surgical center. *See* 2003 Tex. Gen. Laws 2931. In 2013, Texas added a requirement that all abortions be performed in a hospital or ambulatory surgical center, regardless of gestational age. *See* 2013 Tex. Gen. Laws 5017. That requirement was immediately declared unconstitutional. *See Whole Woman's Health*, 136 S. Ct. at 2300.

75. In 1997 and 2011, Texas amended the TRAP law's inspection provisions to make inspections more frequent and burdensome. *See* 2011 Tex. Gen. Laws 346; 1997 Tex. Gen. Laws 4264.

76. In 2012, 2013, and 2017, Texas amended the existing reporting requirements and added new reporting requirements, substantially expanding the scope of information that must be reported and increasing the frequency with which reports must be made. *See* S.B. 8, 85th Leg., Reg. Sess. (Tex. 2017); H.B. 13, 85th Leg., 1st Called Sess. (Tex. 2017); 38 Tex. Reg. 9409, 9592 (Dec. 27, 2013); 37 Tex. Reg. 9831, 9938-41 (Dec. 21, 2012).

77. In 2013, Texas added a requirement that all physicians who perform abortions have admitting privileges at a local hospital. *See* 2013 Tex. Gen. Laws 5013-14. That requirement has been declared unconstitutional. *See Whole Woman's Health*, 136 S. Ct. at 2300.

78. Plaintiffs challenge the following TRAP laws currently in force in Texas:

a. the physician-only requirements codified at Tex. Health & Safety Code §§ 171.003, 171.063(a)(1), 245.010(b); 25 Tex. Admin. Code §§ 139.2(1), 139.53(a)(7), which prohibit licensed, qualified clinicians who are not physicians from providing abortions;

b. the facility licensure requirements codified at Tex. Health & Safety Code §§ 245.003, 245.004, 245.006, 245.009, 245.010(a), 245.0105, 245.023(d); 25 Tex. Admin. Code, ch. 139, which require facilities at which abortions are performed to meet medically inappropriate licensure standards;

c. the ASC requirement codified at Tex. Health & Safety Code § 171.004, which requires abortions to be performed in an ambulatory surgical center or hospital beginning at 16 weeks' gestation (18 weeks lmp); and

d. the reporting requirements codified at Tex. Health & Safety Code §§ 171.006, 245.011, which require abortion providers to report detailed information to the State about their patients and practices.

79. These laws are enforced through civil and administrative fines, professional discipline, and criminal penalties. *See* Tex. Health & Safety Code §§ 171.005, 171.006(j)-(l), 171.064, 245.013-245.015, 245.017-245.022; Tex. Occ. Code §§ 164.055, 165.001-165.008, 165.101-165.103, 165.151; 25 Tex. Admin. Code § 139.33.

80. In the absence of the challenged TRAP laws, abortion providers would be subject to generally-applicable laws concerning scope of practice, 22 Tex. Admin. Code §§ 185.10, 221.12; office-based surgery, 22 Tex. Admin. Code §§ 192.1 – 192.6; recordkeeping, 22 Tex. Admin. Code §§ 165.1 – 165.5; medication dispensing, 22 Tex. Admin. Code §§ 169.1 – 169.8; complaints, 22 Tex. Admin. Code §§ 178.1 – 178.9; investigations, 22 Tex. Admin. Code §§ 179.1 – 179.8; and delegation, 22 Tex. Admin. Code §§ 193.1 – 193.20.

81. The challenged TRAP laws impose burdens on abortion access that are not justified by proportional benefits.

82. These burdens disproportionately impact poor people, people of color, immigrants, and others who are marginalized.

B. Laws That Deny Abortion Patients the Benefits of Scientific Progress

83. The practice of medicine evolves over time as research and technological advancements enable clinicians to deliver care that is safer, more effective, less costly, and higher quality.

84. Texas has enacted laws that prevent abortion patients from enjoying the benefits of scientific progress.

85. Since abortion was legalized in 1973, the biggest advancement in the field of abortion medicine has been the development of mifepristone, a medication that enables safe and effective abortion beginning very early in pregnancy.

86. Mifepristone blocks the hormone progesterone, which is necessary to maintain a pregnancy. In medication abortion regimes, it is used in tandem with misoprostol, a medication that causes the uterus to contract and expel its contents. Mifepristone is taken first, and misoprostol is typically taken six to 48 hours later.

87. Medication abortion can be used very early in pregnancy, as soon as a pregnancy is confirmed. Many abortion providers will not provide an aspiration abortion until the pregnancy can be visualized, typically at 5-6 weeks lmp.

88. Mifepristone was approved for use in the United States in 2000. Between 2004 and 2013, the percentage of total abortions by the medication method more than doubled nationwide, from 10.6 percent to 22.3 percent. The percentage of medication abortions is expected to continue rising, unless legal restrictions interfere with the trend.

89. The percentage of very early abortions—those performed prior to 6 weeks lmp—increased by 16% from 2004 to 2013. The percentage of abortions performed very early in pregnancy is expected to increase further as the use of medication abortion becomes more common.

90. Recognizing the potential of medication abortion to improve access to abortion care, abortion opponents have sought to halt its scientific development and restrict its availability.

91. Plaintiffs challenge the following Texas laws that impose restrictions on the use of medication abortion:

a. the dosage and administration restrictions codified at Tex. Health & Safety Code § 171.063(a)-(b); 25 Tex. Admin. Code § 139.53(b)(3), which prevent abortion providers from incorporating scientific advancements into the provision of medication abortion;

b. the physician examination requirement, codified at Tex. Health & Safety Code § 171.063(c); 25 Tex. Admin Code § 139.53(b)(5), which requires a redundant and medically unnecessary physical examination by the physician who provides the medication abortion;

c. the manufacturer's label distribution requirement codified at Tex. Health & Safety Code § 171.063(d)(1), which requires abortion providers to distribute the manufacturer's label for mifepristone to abortion patients even though it may contain information that is redundant, inconsistent with, and/or confusing in light of the patient's written discharge instructions; and

d. the follow-up visit requirement codified at Tex. Health & Safety Code § 171.063(c)-(f); 25 Tex. Admin. Code § 139.53(b)(4), which imposes medically unnecessary restrictions on a patient's options for obtaining follow-up care after a medication abortion.

92. These laws are enforced through civil and administrative fines, professional discipline, and criminal penalties. *See* Tex. Health & Safety Code § 171.064; Tex. Occ. Code §§ 164.055, 165.001-165.008, 165.101-165.103, 165.151; 25 Tex. Admin. Code § 139.33.

93. The challenged restrictions on medication abortion impose burdens on abortion access that are not justified by proportional benefits.

94. These burdens disproportionately impact poor people, people of color, immigrants, and others who are marginalized.

95. Texas has also prohibited the use of telemedicine and telehealth in the provision of abortion care.

96. Texas law defines "telemedicine medical service" as "a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology." Tex. Occ. Code § 111.001(4).

97. Texas law defines "telehealth service" as "a health service, other than a telemedicine medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology." Tex. Occ. Code § 111.001(3).

98. The use of telemedicine and telehealth is rapidly increasing in Texas and throughout the United States.

99. Telemedicine and telehealth improve healthcare access and decrease healthcare costs.

100. Texas recently amended its laws to facilitate the use of telemedicine and telehealth services in the State. *See* S.B. 1107, 85th Leg., Reg. Sess. (Tex. 2017).

101. Rather than apply the same reasonable regulations concerning telemedicine and telehealth services to abortion providers that it applies to all other healthcare providers, Texas has prohibited abortion providers from utilizing telemedicine and telehealth. Tex. Occ. Code § 111.005(c).

102. Medication abortion can be provided safely and effectively using telemedicine and/or telehealth.[26]

103. Other abortion-related services, including pre-abortion counseling, can be provided safely and effectively using telemedicine and/or telehealth.

104. In states where the use of telemedicine and telehealth in abortion care is lawful, patients report a high degree of satisfaction with abortion services provided via telemedicine or telehealth.[27]

105. Plaintiffs challenge the following Texas law that imposes an explicit restriction on the use of telemedicine and telehealth in abortion care:

a. the telemedicine and telehealth ban codified at Tex. Occ. Code § 111.005(c), which prevents a health care provider who performs abortions from using telemedicine or telehealth services even when all of the regulatory requirements for using such services are satisfied.

106. The challenged restriction is enforced through professional discipline. *See* 22 Tex. Admin. Code § 174.7.

107. Plaintiffs also challenge Texas laws that impose *de facto* restrictions on the use of telemedicine and telehealth in abortion care, including: the physician examination requirement codified at Tex. Health & Safety Code § 171.063(c); 25 Tex. Admin. Code § 139.53(b)(5); the ultrasound requirement codified at Tex. Health & Safety Code § 171.012(a)(4)-(7); Tex. Occ. Code

[26] *See* Daniel Grossman & Kate Grindlay, *Safety of Medical Abortion Provided through Telemedicine Compared with in Person*, 130 Obstetrics & Gynecology 778, 778 (2017); Daniel Grossman, Kate Grindlay, Todd Buchacker, Kathleen Lane & Kelly Blanchard, *Effectiveness and Acceptability of Medical Abortion Provided through Telemedicine*, 118 Obstetrics & Gynecology 296, 296 (2011).

[27] *See* Kate Grindlay, Kathleen Lane & Daniel Grossman, *Women's and Providers' Experiences with Medical Abortion Provided through Telemedicine: A Qualitative Study*, 23 Women's Health Issues e117, e117 (2013); Grossman *et al.*, *Effectiveness and Acceptability* at 296.

§ 164.0551; 25 Tex. Admin. Code §§ 139.50, 139.51(3)-(4), 139.52, 139.53(a)(3), 139.53(b)(6)(c); and the procedural requirement that prohibits use of audio and video recordings codified at Tex. Health & Safety Code § 171.012(b); Tex. Occ. Code § 164.0551.

108. In the absence of the challenged restrictions, abortion providers would be subject to generally-applicable regulations concerning the use of telemedicine and telehealth services. Tex. Occ. Code §§ 111.001 – 111.007; 22 Tex. Admin. Code §§ 174.1 – 174.9.

109. The challenged restrictions on the use of telemedicine and telehealth in abortion care impose burdens on abortion access that are not justified by proportional benefits.

110. These burdens disproportionately impact poor people, people of color, immigrants, and others who are marginalized.

C. Mandatory Disclosure and Waiting-Period Laws

111. In *Casey*, the Supreme Court held that states may take measures to ensure that a woman's decision to end a pregnancy is informed "as long as their purpose is to persuade the woman to choose childbirth over abortion" and they do not impose "an undue burden on the right." 505 U.S. at 878.

112. Texas has enacted a series of mandatory disclosure and waiting-period laws that far exceed the authorization granted in *Casey*. As with its TRAP laws, Texas has made these laws incrementally more burdensome over time.

113. Texas first enacted mandatory disclosure and waiting-period requirements for abortion in 2003. The 2003 law required abortion providers to provide certain information to patients seeking abortion care "orally by telephone or in person" at least 24 hours before the start of an abortion. 2003 Tex. Gen. Laws 2931-32. It also required abortion providers to offer their patients certain informational materials published by the State. *Id.* at 2931-33.

114. Texas amended this law in 2011, enacting numerous additional procedural requirements, including that certain information must be provided by the same physician who will perform the abortion; that the information must be provided in person unless the patient lives 100 miles or more from the nearest abortion provider; and that the information may not be provided by audio or video recording. 2011 Tex. Gen. Laws 343-46.

115. In 2011, Texas also added a requirement that abortion patients undergo an ultrasound examination narrated by the physician who will perform the abortion. *Id.* The narration must include specific information about the physical characteristics of the embryo or fetus. *Id.* The physician or a certified sonographer must display the ultrasound image in the patient's line of sight, regardless of whether the patient wants to view it, and make any embryonic or fetal heart tones audible regardless of whether the patient wants to hear them. *Id.*

116. Plaintiffs challenge the following mandatory disclosure and waiting-period laws currently in force in Texas:

a. the state-mandated information requirements codified at Tex. Health & Safety Code § 171.012(a)(1)-(3); Tex. Occ. Code § 164.0551; 25 Tex. Admin. Code §§ 139.50, 139.51(3)-(4), 139.52, 139.53(a)(3), 139.53(b)(6)(c), which—as applied by Defendants Young and Hellerstedt—require abortion providers to give irrelevant, medically inaccurate, and ideologically charged information to their patients;

b. the state-printed materials requirement codified at Tex. Health & Safety Code § 171.013; Tex. Occ. Code § 164.0551; 25 Tex. Admin. Code §§ 139.50(3)-(6), 139.51(9), 139.52, 139.53(a)(3), (b)(6)(c), which require abortion providers to distribute materials published by Defendants Young and Hellerstedt that contain irrelevant, medically inaccurate, and ideologically charged information;

c. the ultrasound requirement codified at Tex. Health & Safety Code § 171.012(a)(4)-(7); Tex. Occ. Code § 164.0551; 25 Tex. Admin. Code §§ 139.50, 139.51(3)-(4), 139.52, 139.53(a)(3), 139.53(b)(6)(c), which requires abortion providers to perform an often redundant and medically unnecessary ultrasound examination and provide a real-time narration while patients are undressed and—in the majority of cases—being examined with a vaginal probe;

d. the waiting-period requirements codified at Tex. Health & Safety Code §§ 171.012(a)(4)-(5), (b), 171.013; Tex. Occ. Code § 164.0551; 25 Tex. Admin. Code §§ 139.50(b), which impose mandatory waiting periods on abortion patients; and

e. the procedural requirements codified at Tex. Health & Safety Code §§ 171.012(a)(1)-(7), (a-1), (b)-(c), 171.0121; Tex. Occ. Code § 164.0551; 25 Tex. Admin. Code §§ 139.50(a), (c); 139.51(3)-(4); 139.52; 139.53(a)(3), (b)(6)(c), which impose burdensome and medically unnecessary procedural mandates on abortion providers in connection with the foregoing requirements.

117. These laws are enforced through civil and administrative fines, professional discipline, and criminal penalties. *See* Tex. Health & Safety Code § 171.005, 171.018; Tex. Occ. Code §§ 164.055, 165.001-165.008, 165.101-165.103, 165.151; 25 Tex. Admin. Code § 139.33.

118. Independent of the mandatory disclosure and waiting-period laws, Texas imposes informed consent requirements on all healthcare providers. *See* Tex. Civil Practice & Remedies Code §§ 74.101 – 74.107; 25 Tex. Admin. Code §§ 601.1 – 601.9.

119. The Texas Legislature created the Texas Medical Disclosure Panel "to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their

patients and to establish the general form and substance of such disclosure." Tex. Civil Practice & Remedies Code § 74.102(a).

120. The Texas Medical Disclosure Panel has determined the risks and hazards that must be disclosed in connection with aspiration abortion and D&E, *see* 25 Tex. Admin. Code § 601.2(g)(13), as well as medication abortion, *see* 25 Tex. Admin. Code § 601.2(g)(14).

121. Abortion providers would be required to comply with the Texas Medical Disclosure Panel's directives even if the challenged mandatory disclosure and waiting-period laws were struck down.

122. The Texas Medical Disclosure Panel has determined that the risks of aspiration abortion and D&E abortion that warrant disclosure are the same as the risks of diagnostic or therapeutic dilation and curettage of the uterus, except that the risks of the abortion procedures also include failure to remove all products of conception. *Compare* 25 Tex. Admin. Code § 601.2(g)(13) *with* 25 Tex. Admin. Code § 601.2(g)(12).

123. The Texas Medical Disclosure Panel has determined that the risks of medication abortion that warrant disclosure are hemorrhage with possible need for surgical intervention; failure to remove all products of conception; and sterility. *See* 25 Tex. Admin. Code § 601.2(g)(14).

124. The Texas Medical Disclosure Panel does not require healthcare providers to identify breast cancer as a risk of any abortion procedure.

125. The state-mandated information requirements require abortion providers to discuss the risk of breast cancer with abortion patients and require abortion patients to sign a form certifying that they have received information about the risk of breast cancer.

126. The state-printed materials discuss the risk of breast cancer following an abortion.

127. The claim that having an abortion increases a person's risk of breast cancer is not supported by scientific evidence. Leading medical associations including the American Cancer Society have debunked this false claim.[28]

128. The state-printed materials contain other false, misleading, and medically inaccurate information—including other purported risks of abortion that have not been identified by the Texas Medical Disclosure Panel.

129. The challenged mandatory disclosure and waiting-period laws do not constitute reasonable regulation of the practice of medicine.

130. The challenged mandatory disclosure laws compel abortion providers to say things to their patients that they would not otherwise say.

131. The challenged mandatory disclosure and waiting-period laws impose burdens on abortion access that are not justified by proportional benefits.

132. These burdens disproportionately impact poor people, people of color, immigrants, and others who are marginalized.

D. Parental Involvement Laws

133. Texas' parental involvement laws require minors—*i.e.*, people younger than eighteen years old—to obtain approval from a parent or judge before having an abortion, even in cases where the minor's parents are estranged, deceased, negligent, or abusive. They also require minors to satisfy burdensome procedural requirements.

134. Most minors voluntarily involve a parent in decisions about pregnancy and abortion.

[28] *See Abortion and Breast Cancer Risk*, American Cancer Society, https://www.cancer.org/cancer/cancer-causes/medical-treatments/abortion-and-breast-cancer-risk.html (June 19, 2014).

135. Some minors have good reasons for not involving a parent in decisions about pregnancy and abortion—including that their parents are not involved in their lives or they reasonably fear violence or abandonment by their parents.

136. Texas law permits minors to consent to all pregnancy-related medical care except abortion. *See* Tex. Fam. Code § 32.003.

137. For other kinds of medical care, Texas law permits nonparents, such as grandparents, adult siblings, and other relatives, to consent on behalf of a minor. *See* Tex. Fam. Code § 32.001.

138. Like the other laws challenged by Plaintiffs, Texas' parental involvement laws have become incrementally more burdensome over time.

139. In 1999, Texas enacted a parental notification requirement. 1999 Tex. Gen. Laws 2466-2471. It required abortion providers to give notice to the parent or guardian of a minor seeking abortion care at least 48 hours in advance of the procedure. *Id.* at 2466-67. It also created a mechanism, which has come to be known as "judicial bypass," through which a minor could obtain a court order exempting the minor from the parental notice requirement. *See id.* at 2468-70.

140. In 2005, Texas added a parental consent requirement to the parental notice requirement. 2005 Tex. Gen. Laws 734-35. It prohibits a physician from providing an abortion to a minor without the written consent of the minor's parent or guardian or a judicial bypass order. *See id.* at 734.

141. In 2015, Texas added an identification requirement. 2015 Tex. Gen. Laws 1698. It requires physicians to request "proof of identity and age" from every woman seeking abortion

care. *Id*. If a woman cannot provide proof of identity and age, the physician must delay the abortion procedure while she attempts to obtain it. *Id*.

142. In 2015, Texas also amended the procedural requirements for judicial bypass to make it more difficult for minors to obtain a judicial bypass order. *See id.* at 1699-1703; Tex. Sup. Ct. R. for Judicial Bypass at 1 (explanatory statement). For example, prior to the amendments, minors could file a judicial bypass application in any county in Texas. As a result of the amendments, minors may only file an application in their county of residence, except in rare circumstances. Likewise, the amendments raised the standard of proof for a minor's application from a preponderance of the evidence to clear and convincing evidence. Prior to the amendments, if a court failed to rule on a judicial bypass application within two business days after it was filed, the application would be deemed granted. Now, if a court fails to rule within five business days, the application is deemed denied. The amendments also prohibit a minor from appearing in court telephonically or by videoconference.

143. In 2017, Texas added additional reporting requirements for abortion providers treating minor patients, on top of the already voluminous reporting requirements that abortion providers must satisfy for all patients. H.B. 215, 85th Leg., 1st Called Sess. (Tex. 2017).

144. The vast majority of minors who seek a judicial bypass in Texas are seventeen years old.

145. Plaintiffs challenge the following parental involvement laws currently in force in Texas:

a. the parental notice and waiting-period requirement codified at Tex. Fam. Code § 33.002, Tex. Occ. Code § 164.052(a)(20), which requires abortion providers to give

48 hours' notice to the parent or guardian of a minor patient before performing an abortion;

b. the identification requirement codified at Tex. Fam. Code § 33.002(j)-(l); Tex. Occ. Code § 164.052(a)(20), which requires abortion patients to provide proof of identity and age or delay their abortion procedure while trying to obtain proof of identity and age;

c. the parental consent requirement codified at Tex. Fam. Code §§ 33.0021, 33.013; Tex. Occ. Code § 164.052(a)(19), which requires abortion providers to obtain consent from the parent or guardian of a minor patient before performing an abortion;

d. the procedural requirements for judicial bypass codified at Tex. Fam. Code §§ 33.003 – 33.007; Tex. Sup. Ct. R. for Judicial Bypass 2.1, 2.2(g), 2.5(b)-(c), 2.5(g), 3.3(f), which govern the process by which pregnant minors may obtain a court order authorizing them to obtain an abortion without parental notice or consent, including:

    i. the venue restriction, codified at Tex. Fam. Code § 33.003(b); Tex. Sup. Ct. R. for Judicial Bypass 2.1(a), which requires that a pregnant minor's application be filed in the minor's county of residence except in rare instances;

    ii. the in-person requirement codified at Tex. Fam. Code § 33.003(g-1); Tex. Sup. Ct. R. for Judicial Bypass 1.5(d), which prohibits the pregnant minor from appearing in court by videoconference, telephone conference, or other remote electronic means;

iii. the heightened burden-of-proof codified at Tex. Fam. Code § 33.003(1), (i-3); Tex. Sup. Ct. R. for Judicial Bypass 2.5(b), which requires pregnant minors to satisfy a clear and convincing evidence standard to prevail on their application;

iv. the compulsory psychological examination codified at Tex. Fam. Code § 33.003(i-I)(4); Tex. Sup. Ct. R. for Judicial Bypass 2.5(c)(4), which authorizes the judge hearing the application to compel the pregnant minor to be evaluated by a mental health professional;

v. the nonsuit prohibition codified at Tex. Fam. Code § 33.003(o); Tex. Sup. Ct. R. for Judicial Bypass 2.1(c), which prohibits pregnant minors from withdrawing their application without permission of the court; and

vi. the pocket veto provisions codified at Tex. Sup. Ct. R. for Judicial Bypass 2.1(g), 2.5(g), 3.2(c), 3.3(f), which provide that a pregnant minor's application or appeal is deemed denied if the court fails to rule on it within the statutorily prescribed time-period;

e. the reporting requirements for minor patients codified at Tex. Health & Safety Code § 171.006, which require abortion providers to report detailed information to the State about their minor patients in addition the detailed information they must report about patients of any age.

146. These laws are enforced through civil and administrative penalties, professional discipline, and criminal penalties. *See* Tex. Fam. Code §§ 33.012, 33.014; Tex. Occ. Code §§ 164.051(a)(1), 164.055, 165.001-165.008, 165.101-165.103, 165.151; Tex. Health & Safety Code § 171.005; 25 Tex. Admin. Code § 139.33.

147. The challenged parental involvement laws impose burdens on abortion access that are not justified by proportional benefits.

148. These burdens disproportionately impact poor people, people of color, immigrants, and others who are marginalized.

E. Criminal Penalties

149. Texas imposes generally-applicable criminal liability on physicians who engage in certain acts of professional misconduct. *See* Tex. Occ. Code § 165.151.

150. In addition to generally-applicable criminal liability, Texas targets abortion providers for additional criminal liability related to all aspects of providing abortion care.

151. Physicians are not subject to additional criminal liability in connection with the provision of any other type of medical care.

152. Subjecting abortion providers to special criminal liability deters healthcare providers from providing abortions.

153. Plaintiffs challenge the following provisions that subject abortion providers to special criminal penalties: Tex. Health & Safety Code §§ 171.018, 245.003(a); Tex. Occ. Code § 165.151 as applied to Tex. Occ. Code §§ 164.052(a)(19)-(20), 164.055, and 164.0551.

154. The challenged criminal penalties impose burdens on abortion access that are not justified by proportional benefits.

155. These burdens disproportionately impact poor people, people of color, immigrants, and others who are marginalized.

F. Limitation on Abortion Funding

156. Section 6.25 of Article 9 of the General Appropriations Act prohibits the distribution of money appropriated by the Act to any individual or entity that "(1) Performs an

abortion procedure that is not reimbursable under the state's Medicaid program; (2) Is commonly owned, managed, or controlled by an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program; or (3) Is a franchise or affiliate of an entity that performs an abortion procedure that is not reimbursable under the state's Medicaid program."[29]

157. The University has interpreted this limitation on abortion funding to prohibit it from granting credit to students who complete a field placement with the Lilith Fund or other organizations that facilitate abortion access.

158. The Lilith Fund does not perform abortion procedures; it is not commonly owned, managed, or controlled by an entity that performs abortion procedures; and it is not a franchise or affiliate of an entity that performs abortion procedures.

159. Granting credit to a student enrolled in a degree program for completing a field placement with a host organization does not constitute a distribution of money to the host organization.

160. The University's degree-granting programs do not constitute government speech.

161. But for the limitation on abortion funding contained in the General Appropriations Act, the University would grant credit to qualifying students who complete a field placement with the Lilith Fund or other Plaintiffs.

162. The University's interpretation of the limitation on abortion funding penalizes the Lilith Fund and other Plaintiffs for their speech about abortion.

[29] Abortion procedures are covered by Texas' Medicaid program only when continuation of a pregnancy would be life-threatening or the pregnancy resulted from rape or incest. *See* 1 Tex. Admin. Code § 354.1167.

163. The University's interpretation of the limitation on abortion funding interferes with the ability of the Lilith Fund and other Plaintiffs to recruit and train prospective employees and associates.

III. BURDENS IMPOSED BY THE CHALLENGED LAWS

164. Individually and collectively, the challenged laws burden abortion access in three ways: they directly burden individuals seeking abortion care; they compound other forms of discrimination and oppression that individuals seeking abortion care must battle; and they threaten the long-term sustainability of the practice of abortion care.

A. Direct Burdens on Individuals

165. The challenged laws impose a number of direct burdens on individuals seeking access to abortion care.

166. The challenged laws decrease the availability of abortion care—unnecessarily limiting the number of abortion providers, the geographic distribution of abortion providers, and the practice settings in which abortion care is provided. As a result, people have fewer options for where to obtain abortion care.

167. The challenged laws delay access to abortion care. As a result, individuals have to wait longer to obtain abortions. Absent the challenged laws, more people would be able to obtain very early abortions, and fewer would need second-trimester abortions.

168. The challenged laws prevent some people seeking a medication abortion from having a medication abortion.

169. The challenged laws increase the cost of abortion care. As a result, patients must pay more money to obtain an abortion procedure. Texas law prohibits both public and private health insurance from covering abortion care in most circumstances.

170. The challenged laws stigmatize abortion care and entrench norms concerning traditional gender roles.

171. The challenged laws increase the distance that many individuals must travel to access abortion care. This makes it harder to find an affordable mode of reliable transportation.

172. The challenged laws force some people to travel out of state to obtain abortion care.

173. The challenged laws increase the time that someone must spend at an abortion facility to obtain an abortion procedure. As a result, individuals must be absent from work, school, and/or family responsibilities for longer periods of time.

174. The challenged laws make it harder for individuals to keep their pregnancy status confidential. This burdens the privacy of all people seeking abortion care and exposes some to the threat of violence and harassment.

175. The challenged laws increase the health risks that people face from pregnancy and abortion.

176. The challenged laws increase the stress and anxiety that people with unwanted pregnancies must manage.

177. The challenged laws lead some people to use illicit means to end or attempt to end a pregnancy.

178. The burdens imposed by the challenged laws exacerbate one another. Decreased availability of abortion care, for example, leads to increased delay and expense. Increased expense leads to further delay for people who have to save up or raise the money for an abortion procedure. Delay makes it harder for individuals to keep their pregnancies confidential and leads to increased cost, stress, and health risks. It also imposes emotional and spiritual burdens on those who find later abortion less acceptable than early abortion.

179. For some people, these burdens are prohibitive. Others find a way to overcome them. But in all cases, they undermine the dignity of individuals who may become pregnant—and their status as equal members of society—by forcing them to endure unnecessary hardship as a condition of obtaining abortion care.

180. The Constitution prohibits states from imposing any burden on people seeking abortion care that is not justified by a proportional benefit, regardless of whether the burden ultimately prevents them from ending their pregnancies. *See Whole Woman's Health*, 136 S. Ct. at 2300, 2309-10. States cannot heap burdens on those seeking abortion care for no valid reason—and the desire to punish or stigmatize people for their reproductive choices is not a valid reason under the Constitution. *See Casey*, 505 U.S. at 851-52, 877.

B. Compounding Discrimination and Oppression

181. The challenged laws burden all people seeking abortion care.

182. These burdens disproportionately impact poor people, people of color, immigrants, and others who are marginalized because they compound the effects of other forms of discrimination and oppression, such as racism and poverty.

183. People living in poverty have a harder time accessing healthcare, including abortion care, than people with greater financial means. The challenged laws compound this hardship, making it exponentially more difficult for poor people to access abortion care and increasing inequities both in the distribution of healthcare and in the ability to exercise constitutional rights.

184. People of color are more likely to be poor than white people. Controlling for income, people of color are more likely to experience bad health outcomes than white people because of the effects of structural racism in our society. In Texas, for example, Black women are

twice as likely as others to die from pregnancy. The challenged laws compound the effects of structural racism.

185. Immigrants often must contend with barriers to healthcare access that people born and raised in the United States do not. These barriers include lack of English proficiency; limitations on movement within a state; and fear of detention by immigration authorities. Indeed, the recent rise in immigration enforcement by federal and local agencies has led some immigrant families to defer or altogether forgo healthcare, including reproductive care.[30] The challenged laws compound these barriers.

186. To accurately assess the burdens that the challenged laws impose on people seeking abortion care, we must examine those burdens in the context of people's actual life experience.

187. The inequity that arises from denying some groups of people the practical ability to exercise fundamental constitutional rights is a burden that requires justification.

C. Threatening the Sustainability of Abortion Care

188. In addition to imposing immediate burdens on abortion access, the challenged laws also threaten the long-term sustainability of the practice of abortion care.

189. As improved access to contraceptives causes the abortion rate to decline, it becomes less economically feasible to provide abortion care in discrete, specialized clinics.

190. This problem is most acute in rural areas that lack a large patient base, but it is a threat even to clinics in large, metropolitan areas.

[30] Ileanna Najaro & Jenny Deam, *Fearing deportation, undocumented immigrants in Houston are avoiding hospitals and clinics*, Houston Chronicle, Dec. 27, 2017, https://www.houstonchronicle.com/news/houston-texas/houston/article/Fearing-deportation-undocumented-immigrants-are-12450772.php (last visited June 14, 2018).

191. Abortion providers need to adapt their practice models to ensure that abortion care will remain accessible to everyone who seeks it.

192. The challenged laws do not afford abortion providers the flexibility they need to evolve in the face of changing circumstances.

193. The challenged laws make it practically impossible to integrate abortion care into more diversified medical settings—including primary care practices.

194. The challenged laws prevent abortion providers from using telemedicine and telehealth to serve patients.

195. If the long-term burdens imposed by these restrictions are not addressed until most or all of the clinics in Texas close, there will be a shortage of abortion providers that prevents some people from accessing abortion care.

196. If abortion providers were not subject to the unique, onerous, and medically unnecessary requirements, restrictions, and penalties embodied in the challenged laws, then more healthcare providers would be willing and able to provide abortion care, and they could do so in a wider variety of practice settings with more diverse revenue streams. As a result, the number and geographic distribution of abortion providers in Texas would increase, and their medical practices would be economically sustainable.

CLAIMS

COUNT I
(Substantive Due Process)

197. The allegations of paragraphs 1 through 196 are incorporated as though fully set forth herein.

198. The challenged laws—individually and collectively—impose an undue burden on access to previability abortion in Texas in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT II
(Equal Protection)

199. The allegations of paragraphs 1 through 196 are incorporated as though fully set forth herein.

200. Each of the challenged laws denies equal protection of the laws to individuals seeking and providing abortion care in violation of the Equal Protection Clause of the Fourteenth Amendment.

COUNT III
(First Amendment—Free Speech)

201. The allegations of paragraphs 1 through 196 are incorporated as though fully set forth herein.

202. The state-mandated information requirements, state-printed materials requirement, and ultrasound requirement violate the freedom of speech of Plaintiffs WWHA and Dr. Kumar.

COUNT IV
(Vagueness)

203. The allegations of paragraphs 1 through 196 are incorporated as though fully set forth herein.

204. As applied by the University, the Limitation on Abortion Funding in the General Appropriations Act is unconstitutionally vague in violation of the Due Process Clause of the Fourteenth Amendment.

COUNT V
(First Amendment—Unconstitutional Conditions)

205. The allegations of paragraphs 1 through 196 are incorporated as though fully set forth herein.

206. As applied by the University, the Limitation on Abortion Funding in the General Appropriations Act imposes unconstitutional conditions on Plaintiffs' freedom of speech and freedom of association, in violation of the First Amendment.

REQUEST FOR RELIEF

Plaintiffs respectfully request that this Court:

A. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing:

a. the challenged TRAP laws; and/or

b. any challenged TRAP law or portion of a challenged TRAP law that is unconstitutional; and/or

c. the challenged laws denying abortion patients the benefits of scientific progress; and/or

d. any challenged law denying abortion patients the benefits of scientific progress or portion of a law denying abortion patients the benefits of scientific progress that is unconstitutional; and/or

e. the telemedicine and telehealth ban as applied to the provision of medication abortion; and/or

f. the telemedicine and telehealth ban as applied to the provision of state-mandated information; and/or

g. the challenged mandatory disclosure and waiting-period laws; and/or

h. any challenged mandatory disclosure or waiting-period law or portion of a challenged mandatory disclosure or waiting-period law that is unconstitutional; and/or

i. the challenged parental involvement laws; and/or

j. any challenged parental involvement law or portion of a challenged parental involvement law that is unconstitutional; and/or

k. the challenged parental involvement laws as applied to seventeen-year olds; and/or

l. the challenged parental involvement laws to the extent that they do not permit grandparents, other adult relatives, and *de facto* guardians to give the required consent and receive the required notice; and/or

m. the challenged criminal penalties; and/or

n. any challenged criminal penalty or portion of a challenged criminal penalty that is unconstitutional; and/or

B. Permanently enjoin Defendant Faulkner and his employees, agents, and successors in office from applying the Limitation on Abortion Funding in the General Appropriations Act to deny students credit for completing field placements with Plaintiffs; and/or

C. Issue a declaratory judgment that the following provisions are unconstitutional:

a. the challenged TRAP laws; and/or

b. any challenged TRAP law or portion of a challenged TRAP law that is unconstitutional; and/or

c. the challenged laws denying abortion patients the benefits of scientific progress; and/or

d. any challenged law denying abortion patients the benefits of scientific progress or portion of a law denying abortion patients the benefits of scientific progress that is unconstitutional; and/or

e. the telemedicine and telehealth ban as applied to the provision of medication abortion; and/or

f. the telemedicine and telehealth ban as applied to the provision of state-mandated information; and/or

g. the challenged mandatory disclosure and waiting-period laws; and/or

h. any challenged mandatory disclosure or waiting-period law or portion of a challenged mandatory disclosure or waiting-period law that is unconstitutional; and/or

i. the challenged parental involvement laws; and/or

j. any challenged parental involvement law or portion of a challenged parental involvement law that is unconstitutional; and/or

k. the challenged parental involvement laws as applied to seventeen-year olds; and/or

l. the challenged parental involvement laws to the extent that they do not permit grandparents, other adult relatives, and *de facto* guardians to give the required consent and receive the required notice; and/or

m. the challenged criminal penalties; and/or

n. any challenged criminal penalty or portion of a challenged criminal penalty that is unconstitutional; and/or

D. Issue a declaratory judgment that the Limitation on Abortion Funding in the General Appropriations Act is unconstitutional as applied by the University; and/or

E. Grant Plaintiffs attorney's fees and costs pursuant to 42 U.S.C. § 1988; and/or

F. Grant such other and further relief as the Court may deem just, proper, and equitable.

Dated: June 14, 2018

Respectfully submitted,

/S/ *Stephanie Toti*

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